State of Maryland / Department of Health and Mental Hygier For State Registrar 35501 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CAROL DENISE KNOX OCTOBER 24, 2004 /Medical 4:55 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2601 Alembic Lane Bowie Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
January 31 California **Funeral** 569-57-2514 1 ☐ M 2 K F Director Yrs. 40 California Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Prince George's Bowie 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2601 Alembic Lane 20716 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 03/29/1988 If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

13. Was Decedent of Hispanic Origin? (Specify Yes or No15 Yes 2 No Specify:

1 Yes 2 XNo Specify: 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 δ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 2 vrs yrs Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Bunnie R. Conley Jerri L. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other treum Eulis Knox/Husband 2601 Alembic Lane Bowie Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Harmony Cemetery 10-30-04 Landover, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 P 23a Fart1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC CARCINOMA RIGHT BREAST /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical thet use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death P.O. | 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? (es 242 No certificate Division of Vital 1 Yes 1 Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1≜ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ို 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3 DOA 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: , 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel c within 24 hours af To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D25784 (MD) casrow ush OCTOBER 26, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN KRASNOW, M.D., VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) State OCT 2 7 2004 Registrar

		1	For State Registrar	State of Maryla	and / Depa	artment rtificate	t of H	ealth and Death	d Mental	Hygien Reg. N		35502
	×,	_	1. Decedent's Name (First, Middle, Las.)					2. Date Mont	of Death	ay Yeer	3. Time of Death
	Physicia /Medic	_	COLETTE AUGUSTA	KURTZ							2004	5:15 a M
>	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of De	ath	4	c. County of Dea	th
			Villa Rosa Nursi	ng Home				llville				George's
	Funeral		5. Social Security Number 6. Se	JM o∭E	rs. last birthday)	If Under Months		If Under 24 H Hours M	in. (Mon	of Birth th, Day, Yea	r) 9. Bir	thplace (State or Foreign ountry)
Ю	Director		212-54-33/9	94	Yrs.				April	11, 1	1910 Kai	nsas
	and *	-	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation						10d. Inside City Limits
	with the Maryland to 28a-f ehow	ō	Maryland Prince Ge	orgois	Cheverl	77						1 X Yes 2 ☐ No
	28a-	Directo	10e. Street and Number	orge s	Onevers	10f. Zip	Code			10g. C	itizen of What C	ountry?
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S	or ital		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No		1 ☐ Yes 2		n, mexican, Pu Specify:	ieno nican, et	(C.)	Black, Whi	te, etc.
8	2 hours after death with the Marylan atural', or items 23s or 28s-f show sale Exarts are must be roulified at	p p	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 162 4	201110	Specify.			Specify:	White
5-0	72 hours after natural, or its	Completed	15. Decedent's Ed (Specify only highest grades)		(Give	dent's Usua kind of wor	rk done d	turing most of v	working	16b.	Kind of Business	/Industry
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2	be filed within 7; ntal Hygiene. nd other than "n. event, the Medi	S	17. Father's Name (First, Middle, Last)	1		Homema	aker	18. Mother's N	Vame /First A		Own Home	
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Ĕ	2 should be and Mental le marked c	J.	James Kennedy 19a. Informant's Name/Relationship (7)	vne Print)	19h Maili	ing Address	(Street a				or Town, State,	Zip Code)
Maryland 21215-0036	alth an 27 io		James W. Kurtz -					Chever				7, -1820
	He He	1	20a. Method of Disposition		b. Place of Disponentery, cre	osition (Nan	ne of		Date		Location - City or	Town, State
Baltimore,	m O		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		-			/27/200	04 Si	lver Spi	ing, Maryland
量	permit. Page Department Important: If eny injury o	H	21. Signature of Funeral Service Licen								al Home	
Ba	Per Imp		PC audatta 9	Jack Jan								ryland 20781
			23a. Part1. Enter the disease, or comp	olications that caused the d	eath. Doubot en	ter the mod	e of dyin	g, such as card	diac or respira	tory arrest,		Approximate Interval Between
	Physician		shock, or heart failure. List only immediate Cause (Final	Senile Den	nentia							Onset and Death Years
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9 ×	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	/Med	IF FEMALE:	23c. If yes, outcome of pre	anancy						23d. Date of de	livery
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P.O.	that the de ed by the detached	ıysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknown			,,_					
	es that igned b	by Physiclan/M	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying c	ause giv	en in Part I.	23e	. Did tobacco	o use contribute t	to the cause of death?
Records,	quires n sign uld be	d b							_	1 🗌 Yes	2 ∑ No 3□P	robably 4 Unknown
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Be	The lay	Completed							_	autopsy performed? Yes 2K	death?	_
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†	Physician: rthis certifica ral director, p	To	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DC	OA Oth	er: 4K Nursin	ig Home 5□	Residence	6 □Other (Sp	ecify)
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Sio	Attending Physician: The reath. sctor: After this certificate hisy the funeral director, page	atic	2 ☐ Accident investigation			М	_	Yes 2 □ No				
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	urs al			wising To the board of		41		- 4-10 004 01	lana and due	t- th	(-)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 X Certifying Ph (Check only 2 Medical Exen	ysician: To the best of my ninar: On the basis of exam and manner stated.	nination and/or i	nvestigation	i, in my o	pinion, death o	occurred at the	time, date a	nd place, and du	e to the cause(s)
	o the	Me	29b. Signature and the of certifier	1 11		290	c. Licens	e number		29d. D	Date signed (Mon	ith, Day, Year)
	- > - 0		1 Tetano	Mella K.			D227	80		0c	tober 25	, 2004
01	15)		30. Name and address of person who	completed cause of death	(Item 23a) (Type							
U			Peter Schissler,				Dri	ve, #43	30, Gre	eenbel	t, MD 20	770-3542
4		ate	31. Date filed (Month, Day, Year)	Registrar's S	ignature -							
	Regist	rar	OCT 2 6 200	4 William	A LO							

State of Maryland / Department of Health and Mental Hygier 0 0 4 35503 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 2 Vear **Physician** 8.39 P M STEPHEN ROBERT KURTZ OCTOBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 1965 PA 7. Age (In yrs. last birthday) 6 Sex 5 Social Security Number **Funeral** 39 191-40-9547 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County in than "natural", or Items 23a or 28a-f show the Medical Examiner roust be notified at 1 Ves 2 No Completed by Funeral Director Middletown MD Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21769 7 Boileau Ct. USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) 12 ulth and Mental Hygie 27 is marked other r traumatic avant, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Daisey Robert R. Kurtz Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trat once. 7 Boileau Ct., Middletown, MD Elizabeth Kurtz (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/28/04 1 Burial 2 Cremation 4 Dopation 5 Other 3 Removal from State Resthaven Memorial Gardens Frederick, MD 5 Other (Apecify) Donald B. Thompson Funeral Home 21. Signature of Fune of Surfice icensee 31 E. main St., Middletown, MD 21769 Part 1. Enter the disease, or commissions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only in a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiac ennesi Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner OBSTRUCTURE Sequentially list conditions, Lany leading to immulate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed respirain that initiated events resulting in death) Last nding physician and Due to (orlas a consequence of Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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1 □ Yes 2 □ No 24a. Was an certificate has autopsy 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl o e Hospital: Other: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28d. Describe how injury occurred 27. Manner of Seath ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation ours after death.
neral Director: A 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 H0061117 Messe @ Danea Cold 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SeverTh ST. Frederick MP 21701 Demels 400 mancuca 32. Registrar's Signature State Registrar

		1	For State Registrar	State of Maryland		rtment of Ho			ene 20	04 35504
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	M I
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9	LXdiiiii		WICOMICO NURSING HOM			SALISBUR)	If Under 24 Hrs.	0.0	MICONICO	
6	Funeral Director		5. Social Security Number 6. Security Number 189–36–3101	7. Age (In yrs. lat	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Yeer)	Birthplace (State or Foreign Country) ASHINGTON, D. C.
•	ס	ļ.,	Usual Residence of Decedent		Town or Lo	cation		0, 11 1.	711 111	10d. Inside City Limits
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	r 28e-	irect	MD WICOMI 10e. Street and Number	CU SA	TIDDO	10f. Zip Code		10	g. Citizen of Wha	t Country?
	23a o	raiD	900 BOOTH STREET				21801		14 Page	USA
36	72 hours after death with the Maryland naturel; or iteme 23a or 28e-f show jical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		American Indian, White, etc. WHITE
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lan	should be nd Mental rmarked o	To Be	LEWIS HENRY RUSSEL	L			IDA LADD			
lary	2 sh and is m		19a. Informant's Name/Relationship (T)			ng Address (Street a				
	ges 1 and t of Health If Item 27 or other tr		DIANNE LANGELER -	20b. Pla	ace of Dispo	AMDEN AVE			20c. Location - Cit	
mor			1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		natory or other place EMETERY		5-2004	SALISBURY	Y, MARYLAND
Baltimore,	permit. Page Department of Importent: If any injury of		21. Signature of Funeral Service Licens	2 Dun	7		AIN STRE	ET, SALIS	BURY, MARY	E, INC. YLAND 21804
T			23a. Part. Enter the disease, or compositock, or heart failure. List only o	lications that caused the death. ne cause on each line.	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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8760,	cate be execute physicien and the burial-trans	ical E		d						
Box 6	ne death certiff the attending thed for use as	Physician/Medical	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	
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of	ding After fune	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Injun Worl	y at		ence 6 Other (ow injury occurred	
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			Mahred	41.1			00605	15	10/25/	04
			30. Name and address of person who	completed cause of death (Item	23a) (Type		ASTERNSHORE	DR. SALI	SBURY, MD	21804
	St Regist	ate	31. Date filed (Month, Day Year)	32. Registrar's Signal	ture	g spon				

	D, 10/26/04, sbb State Registrar		yland / Dep <i>Ce</i>	rtificate	of Deatl	ל	R	eg. No.	U 4	3550
hysician	Decedent's Name (First, Middle, Last)						2. Date of Dea Month OCTOBER	th Day 26	2004	3. Time of Dea 8:00AM
Medical	ANNA M. LEONARD 4a. Facility Name (If not institution, give st	reet and number)		4h City Toy	wn, or Location		CIOBER	4c. Count		0.00ET
caminer	WILLIAM HILL MANOR				ASTON				BOT	
eral	Social Security Number 6. Sex	7. Age ((In yrs. last birthday) If Under 1 Y Months D	Year If Unde Days Hours	or 24 Hrs. Min.	8. Date of Birth (Month, Day AUG 29	Year) 1924	9. Birthp	lace (State or Fo
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	10a. State 10b. County	1	IOc. City, Town or L	ocation					1	0d. Inside City Li
Be Completed by Funeral Director	MD TALBOT		ST. M	ICHAELS						1X Yes 2
Director	10e. Street and Number			10f. Zip Co			1	l0g. Citizen of		•
Funeral	214 B. NORTH ST.	2. Was Decedent Ev	er in U.S. 13.	Was Deceden	216		cify Yes or No-	14. Ra	Ce - Americ	
by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【 Divorced	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		If Yes, specify 1 ☐ Yes 2 🖔			cify Yes or No- Rican, etc.)	Specia	ick, White, fy: Wh	etc. HITE
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	12 17. Father's Name (First, Middle, Last)	00	H	OMEMAKE		her's Name	(First, Middle,			
To Be	JOHN SEDGEWICK M	URPHY					Y JONES		-	
	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mail	ling Address (S	Street and Num	ber or Rura	Route Numbe	r, City or Town	, State, Zip	Code)
	ROBIN M. ISHAM/DAU	GHTER					ON, DE		O1 T	
	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	emoval from State		matory or other	er place)		ate	20c. Location		
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once	21. Signature of Funeral Service License		, F	ELLOWS,	HELFE	NBEIN	& NEWN.	AM FUNE	ERAL E	HOME PA
once.	23a Part1 Enter the disease, or complic	cations that caused the	he death. Do not er						,01	Approximate Interval Between
ก	shock, or heart failure. List only one Immediate Cause (Final	Acut	Myocan	dist	Trifas	ctres	d			Onset and Dea
al	disease or condition resulting in death)	_	constituence of):		0	. 70	1			2101
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xan	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	ellety)					3
dical	٥									
Med	IF FEMALE:									
lan/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of	Fetal death 3	□Ectopic preg				1	ate of delive onth	ery Day Yea
Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at ti 9☐Unknown	me or death 5	Other (speci	my)					
	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cau:	se given in Pai	t I.	23e. Did to	bacco use cor	ntribute to t	he cause of deat
ed by	Hypertension						1 □ Y	es 28No	3 ☐ Prot	oably 4 □Unk
Completed							24a. Was autop	sv	Were auto	psy findings ava
mo							perfor	med? 2€ No	death?	
Be (25. Was case referred to medical examiner?					ce of Death	(Check only o	ne)		
2	1 ☐ Yes 2 No 27. Manner of Death	ospital: 1 Inpatien			-	No. of Lot	ne 5 🗆 Resid 28d. Describe h			ý)
tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	M 280	:, Injury at Work? 1 ☐ Yes 2					
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	treet, factory, o	office	:	28f. Location (S City or Tow		ber or Rura	al Route Numbe
	29a. Certifier 1 Certifying Phys (Check only one)	iician: To the best of her: On the basis of a and manner state	examination and/or	ath occurred at investigation, in	the time, date n my opinion, d	and place, a eath occurr	and due to the ded at the time, d	cause(s) and material	nanner as s , and due to	tated. the cause(s)
100				29c. L	License numbe	or .	:	29d. Date sign	ed (Month,	Day, Year)
Medical	29b. Signature and title of certifier							11/1/	1/1/1	/
Medi	29b. Signature and title of certifier	yue,	\mathcal{M}) 42R1	16		10/2	6/07	
Medical Certification: 7	30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type	a. Print)) 428 i	16	0. /	FAIR	004	M) 21

State of Maryland / Department of Health and Mental Hygieney For State Registra 35506 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Paul Thomas Lezon October 29 2004 8:40 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 □ F Months Days Hours 78 Director 218-14-4670 Feb 04, 1926 Virginia Usual Residence of Decedent 42 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:1950-1952 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator 8 Canning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Lezon ပ Catherine Krol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is rr any injury or other traum <u>once.</u> Francis Lezon/Brother 803 J College Lane Apts., Salisbury, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

` 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Cremetory |Nov. 1, 2004 |Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Harder P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Diabeles disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Film Palin attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by astritis 2 No 1 Tyes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 20 No 1 ☐ Yes 2 ☐ No 1 Yes the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Beath (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No I Director: A М 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours at To the Funaral Discompletely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SNE AMMDW HOW DO060120 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 hospital Rd. Prince Frederick, mp 20678 tiagethmn, MD 32. Regist ar's Signature 31. Date filed (Month, Day, Year) State 0 3 2004 > Registrar

State of Maryland / Department of Health and Mental Hygien 2004

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	iner	4a Facility Neme (If not institu	_					4	b. City, Tov	vn, or Loca	tion of Deat	n 4c. Count	y of Death		
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	1	5. Social Security Number	6. Sex 1 □ N	2□ F /.	92	Yrs.	Month		Hours	Min.	Date of Bir (Month, Da 10/25/		COUNT		te or Foreign
	r	216-41-7608 Usual Residence of Decedent		Λ	92_						.0/23/	1711	CHANA	.1	
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	Director	10e. Street and Number					10f.	Zip Code				10g. Citizen of	What Coun	try?	
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	Funeral	11. Marital Status	12.	Was Decede	ent Ever in U	S. 13	. Was De	edent of H	ispanic Orig	gin? (Speci	fy Yes or No)- 14. Ra	ace - America		١,
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		19a. Informant's Name/Relat		•											
		PHUNG TRIEU -	DAUGH	LEK	20h F	9100 Place of Dis			OVE LA	ME, C	Date	RSBURG, 20c. Location		_	9
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		23a. Part1. Inter the disease shock, or heart failure.	e, or complica List only one	tions that cau	used the deat ch line.	h. Do not e	nter the n	ode of dyin	ig, such as	cardiac or	respiratory a	ırrest,	ì	Approxi Interval	mate Between nd Death
	n		,										1	Olisel a	nd Death
3		Immediate Cause (Final disease or condition	а	1	EN	TRIC	COL	A R	F13	3216	LATIC	Sc			
I	r a _	resulting in death)	۵			r as a cons							1		
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	Examiner	Sequentially list conditions,			Due to (d	or as a cons	equence	of):							
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	by										24a Wa	s an autopsy	24b. We	ere autor	sy findings
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	Be	25. Was case referred to me examiner?		spital:				DOA Oth			(Check only				
	70	1 Yes 2 No	1,10	1 ☐ Ing 28a. Date of		ER/Outpat 28b. Time		DOA 28c. Injur	NU NU			idence 6 00 how injury occ		V)	
	Certification:	27. Manner of Death 1 Natural 5 □ Pe		(Month,	Day Year)	Injury		loW	rk? Yes 2□		Id. Describe	now injury occ	ullou		
	cat	Z L Acolden	vestigation ould not be	Office Place of	of Injury - At h	omo form			163 2		of Location	(Street and Nur	nber or Rura	al Boute	Number.
	Ę	4 ☐ Homicide de	termined		g, etc. (Special		Stieet, iac	tory, office				wn, State)	7,007 07 7,07 0		,
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	edlcai (29a. Certifier 15 Cert (Check only 2 Med	Ical Exemine	r: On the bas	is of examina	tion and/or	investiga	ion, in my c	pinion, dea	th occurred	at the time	cause(s) and i , date and place	e, and due to	the cau	ise(s)
	Mec	N	rtifier	and manne	stated.	1		29c. Licens	e number			29d. Date sign	ned (Month,	Day, Ye	ar)
	_	29D. Signature and title vice	1	1). \		/						·			
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,	/	30. Name and address of per	rson who com	pleted cause	of death (Iter	n 23a) (Typ									8न4
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiere 35508 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 10 12:55P M Lowery /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Clinton Southern Maryland Hospital Il Under 1 Year | Il Under 24 Hrs. 8. Date of Birth Month, Day, 03 01 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 11X M 2□ F 1910 Lynchburg, S.C. Yrs. Director 94 248-18-6870 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itame 23a or 28a-f show the Medical Examinar must be notified at Fort Washington Yes 2 □ No Prince Georges Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20744 USA 3412 Gennene Lane death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry iring most of working is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Safeway Warehouseman 2 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Menta! Healt: If item 27 is marked ott Lillie McCrae Melton Lowery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3412 Gennene Lane Fort Washington, Md. 20744 <u>Virginia</u> Lowery/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 50 permit. Page Department of Importent: If any Injury or once. Cedar Hill Cemetery 10-26-04 Suitland, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, D.C. 20011 mare Approximate Interval Between Onset and Death Intel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician unthown /Medical Due to for as a consequer Examiner a-Knows Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsuguenea of Examiner The law requires that the death certificate be executed burial-transit the attending physician and thed for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4 Pregnant at time of death be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 🗆 No 1 Yes 2 No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient 1 ☐ Yes 2 Certification: To 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire To the Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 0 do Bes, 201 5045

State Registrar

DHMH 17 Rev 1/2001

31. Date liled (Month, Day, Year) 2 7 2004



son who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

	1	For State of Maryland / Depa State Registrar	rtment of Health and M tificate of Death		eme 0 0 4	35509
Physician	1	. Decedent's Name (First, Middle, Last) ARTHUR WILLIAM LAKE		2. Date of Death	Day HA 200	3. Time of Death
/Medical Examiner	_	a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	001070	4c. County of Dea	ath
		Doctor's Community Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Lanham If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Ge	
Funeral Director	1	189-34-3394 1⊠M 2□F 65 Yrs.	Months Days Hours Min.	June 19,	1939 Pe	rthplace <i>(State or Foreign</i> Country) nnsylvania
	- }-	Jsual Residence of Decedent			1707	
ehow		10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits 1 X Yes 2 □ No
vith the Ma	3	Maryland Prince George's Bowie	10f. Zip Code	10	g. Citizen of What C	
3a or		15604 Peyton Court	20716		U.S.A.	, out it y
ifter death wire fems 23a	1		Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
les 1 and 2 should be filed within 72 hours atter death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other treumatic event, the Modical Exaction constitution of To Re Commission by Finneral Director.	2	1 Never Married 201 Married 100 Yes 2 No. 1962 — 1	☐ Yes 2 No Specify:	riloan, etc.,	Black, Wh	White
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marka marka	-	Lot Lake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Helen Ma		City or Town, State.	Zio Code)
ING 2 alth a 27 is or treu		Shirley A. Lake - Wife 15604	Peyton Court, Bo	owie. Mar	vland 207	16
of He of He of He	1	20a Method of Disposition 20b. Place of Dispos			Oc. Location - City o	
Dallillion Permit. Pages Department of I mportent: If ite iny injury or or tage.		`4 □Donation 5 □Other (Specify) MD Veteran				, Maryland
permit. Pages Department of Importent: If it any injury or o			Name and Address of Facility Gas 739 Baltimore Ave			
	Ì	23a. Part1. Enter the disease, or complications that caused the death. Dispot enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	13 failur	n.l.		Onset and Death
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The COTIGS, F.O. BOX 00/00, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	30101		Other (specify)		Month	Day Year
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The law require rate has been slipage 2 should be	200			24a. Was an	24b. Were a	autopsy findings available completion of cause of
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Attending or death. ector: Afte by the fune		1 → Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		. ,	
LIVISION OI VITA tel or Attending Physicien: salter death. el Director: After this certification by the funeral director. TO Box		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streething building, etc. (Specify)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or F , State)	Rural Route Number,
Hospitel of the hours at Funerel D tely filted in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	A construct at the time, date and alone	and due to the co	(a) and manage	
To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	SOILCE	(Check only one) 2 Medical Examiner: To the best of my knowledge, death (Check only one) and manner stated.	restigation, in my opinion, death occur	red at the time, da	te and place, and du	is stated. le to the cause(s)
To the Vithin 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mor	nh, Day, Year)
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K15/1/a		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Doc Lane	Comi	00	100
State	,	31. Date filed (Month, Day, Year) 38. Registrar's Signature	Declars	Com	nunf	Maritar
Registra		OCT 2.6 2004 Ket K free	At a		ľ	

Amend item#2, perm 5337, 1111, 17/04 Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2004 355 I N Certificate of Death Reg. No 2. Date of Death Oct . 21 1. Decedent's Name (First, Middle, Last) 2004 Time of Death Physician 12:40 P M Anthony Loglisci 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1X M 2□ F 168-16-1424 81 Director 03/13/1923 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or Itams 23a or 28a-f show other treumstic event, the Medical Examinar must be notified at 1 XYes 2 No Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 199 Rollins Avenue, Apt. 419 U.S.A. 20852 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 Z No
If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Masonry Tile Setter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Vennetti Frank Loglisci 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 143 Hill Street, Ansonia, Connecticut 06401 Frank Loglisci, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or Ft. Lincoln Crematory 10/24/2004 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ricensee 22. Name and Address of Facility Simple Tribute any it 1040 Rockville Pike, Rockville, Maryland 20852 4 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on e Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final Physician 48 hours Septic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Infarcted Bowel Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of) the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year jo in the past 12 months? 1 □ Yes 2 □ No Dav 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Myelofibrosis autopsy performed? 1 ☐ Yes 2 🖁 No 2□ No 1 🗆 Yes Gastric ulcer with hemorrhage director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🏋 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number October 22, 2004 D32917

Within 24 hours after death.

Yo the Funeral Director: After thi completely filled in by the funeral is Division To the

The law requires that the death certificate be executed

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permit. Page Department of Importent: If

and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registra

32. Registrar's Signature 31. Date filed (Month, Day, Year) Carlo OCT 25 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rahul Giwtra, MD, 12016 Georgia Avenue, Wheaton, Maryland 20902

		1- State Amend Item 5 State of Ma. Registrar	syland / Depa 3/211-15-0 Cer	rtment of Hea 4 tas tificate of De	alth and M eath		ne . No 2004	35512
Physic		Decedent's Name (First, Middle, Last) RUTH IRENE LEES				2. Date of Death	26 2004	3. Time of Death 3:55A M
/Med Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc			4c. County of Death	
Funera		18409 KINGSHILL ROAD 5. S 21 Sa2	(In yrs. last birthday)		Under 24 Hrs.	8. Date of Birth	MONTGOME 9. Birth	Place (State or Foreign
Directo			68 Yrs.	Months Days H	lours Min.	10V 29 1	935 Cou	MD
laryland show		10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
the Mar	Director	MD MONTGOMERY 10e. Street and Number	GERMAN'			10-	Cities of Miles Co.	1 ☐ Yes 2 ☑ No
h with 1 23a or 3		18409 KINGSHILL ROAD		10f. Zip Code 20874		109	. Citizen of What Cou USA	ntry?
I E, INICALLY INITION AT INITIONS. I and 2 should be filed within 72 hours after death with the Maryland f Health and Menial Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanthar must be relitized at	by Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces?	If	/as Decedent of Hispar Yes, specify Cuban, M ☐ Yes 2 No Si	nic Origin? (Spe Mexican, Puerto l Specify:	ocify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: WH	, etc.
72 hou		15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation	n ng most of workii	חמ	b. Kind of Business/Ir	
I within iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+	life. D	O NOT use retired) E SERVICE	-	DINATOR	ONTGOMER POLICE	RY COUNTY
should be filed and Mental Hyg	To Be C	17. Father's Name (First, Middle, Last) GEORGE SNYDER			Mother's Name	(First, Middle, Ma	iden Sumame)	
Mary d 2 sho th and life mark		19a. Informant's Name/Relationship (Type, Print) GEORGE LEES / SPOUSE		Address (Street and I				
es 1 and of Health of Health of Itam 27	1.3	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispos		-		c. Location - City or T	
Pag nent ant: 1		'4 □Donation 5 □ Other (Specify)		N MEM. GA	1	30/04 I	aVALE, N	1D
Dennit. Departi		21. Signature of Fundral Service Litensee	H	Name and Address of ILTON FUN	VERAL I		E. MD 2	.0838
Physiciar /Medica Examine		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a	ne death. Do not ente	r the mode of dying, su	uch as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
portory, icate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):					
The law requires that the death certific ate has been signed by the ettending page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 ryonths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3 1	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
wrequires that been signed b	र्व	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause given in	Part I.		co use contribute to t	he cause of death?
VICAL DECOLOR	Completed					24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
Physician This certifinal director	To Be		2 ER/Outpatient	3□ DOA Other: 4		(Check only one)	e 6 ☐Other (Speci	(y)
ding I	ertification;	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28c. Injury at Work? M 1 □ Yes	2 🗆 No	8d. Describe how		
To the Hospital or Attent within 24 hours after deatt To the Funaral Directors completely filled in by the	Certifi	4 Homicide determined 256. Place of injury building, etc.				City or Town, S		·
To the Hospital or within 24 hours afte To the Funaral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or inve	occurred at the time, destigation, in my opinion	late and place, a on, death occurre	and due to the caused at the time, date	e(s) and manner as s and place, and due t	tated. the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier		29c. License nur			Date signed (Month,	
		30. Name and address of person who completed cause of dea	th (Item 23s) (Type 5	D2330			0-26-09	
10		VICTOR M. PRIEGO, M.D. 64	120 ROCKI	Print)	# 4100	BETH	SDA, MO	20817
S Regis	tate trar	31. Date filed (Month, Day, Year) 2 7 2004	s Signature	& Som	61			

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	Examin	er	University of Ma	1			1).	more		10. 000	, 0, 0000	
	Funeral		5. Social Security Number 6. S	/		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2	Year)	9. Birthp	place (State or Foreign
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	yland yland		10a. State 10b. County		10c. City	, Town or Lo	ocation				1	0d. Inside City Limits
	e Mar	ctor	Maryland Ceci	1				ryville				1 X Yes 2 □ No
	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f show fre Medical Evarulter must be notified at	Funeral Director	10e. Street and Number 513 Lighthouse Dr	ive			10f. Zip Code	21903	1	0g. Citizen of	What Cour	*
	ms 23	nerai	11. Marital Status	12. Was Decedent		S. 13.	Was Decedent of H		pecify Yes or No-		ce - Americ	can Indian,
9	or Ita	/ Fur	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ⊠Yes 2 ☐ If Yes, Give	No		If Yes, specify Cuba 1 □ Yes 2 🕱 No	Specify:	Hican, etc.)	Speci	ack, White,	
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and	should be filed withir nd Mental Hygiene. marked other tha imatic evant, I'e. I'e.	Be	17. Father's Name (First, Middle, Last) Elbert I	:11,,				18. Mother's Nam	e (First, Middle, I Elizabet		,	
ΪŽ	should be and Mental is smarked o	2	19a. Informant's Name/Relationship (-		19b. Mailii	ng Address (Street	and Number or Ru				Code)
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ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ite Medical Eventures must be notified at		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	lace of Dispo emetery, crei	osition (Name of matory or other plac	ce)		20c. Location	•	
Baltimore, Maryland 21215-0036	t. Pag rtment rtent:		* 4 ☐ Donation 5 ☐ Other (Specify	1)	Ho	•	l Cemeter		27/04 I	Port De	eposit	, Maryland
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П			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	ofications that caused one cause on each li	the death	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
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	Examiner			Due to (or as	No W	,						
0	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts.)	Due to (or as								
1	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ							
760,	eath certificate be executed attending physician and for use as the burial-transit	cai E	(d.								
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	res that igned b	by Pt	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use cor	ntribute to th	ne cause of death?
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Vital F		e Co	25. Was case referred to medical					00 Place of Page	perform 1 Yes 2 th (Check only on		1 ☐ Yes	21 X No
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isio	ttanding F death. ctor: After	icati	2 Accident investigation 3 Suicide 6 Could not be		un - At ho	ome farm et	M 1 □	Yes 2 □No	28f. Location (St.	reet and Num	her or Rura	I Route Number
Δ	al or A after I Dirac d in by	Certification:	4 Homicide determined	building, et	c. (Specify	/)	cor, ractory, once		City or Town	, State)	201 01 71014	, riodio ramber,
	To the Hos, itel or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fr	edical	(Check only 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examinal	tion and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ate and place.	anner as st , and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number	2	9d. Date signe	ed (Month, I	Day, Year)
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Baltimore, Physician P.O. Box 68760, Records, of Vital Division

Examiner and I-transit The law requires that the death certificate be executed attending physician a for use as the burialas signed by the a been page ; To the Hospital or Attanding Physician: this After death. Diractor: in by the within 24 hours after To tha Funaral Dira

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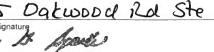
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29b.

erson who completed cause of death (Item 23a) (Type, Print)

2 8 2004



29c. License number

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	1	For State Registrar	Sta	te of M	Maryland	d / Depa <i>Cer</i>	artment of H	lealth a Death	and Men		gien 2 0	04	35515
		1. Decedent's Name (First, Midd.	le, Last)							ate of Dea	th Day	Year	3. Time of Death
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Examin		4a. Facility Name (If not institutio	n, give street a	nd numbe	er)		4b. City, Town, or	r Location of	of Death		4c. County	of Death	1
		Keninsula leg	ional 1			rter	Salis	56409	4		W	CON	rico
Funeral Director		5. Social Security Number 221-10-5498	6. Sex 1 M 2		Age (In yrs. la 82	ast birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. AUC	ate of Birth Month, Day	1 9 2 2	Cou	place (State or Foreign intry) LAWARE
2		Usual Residence of Decedent			10a Cin	, Town or Lo	nation						10d. Inside City Limits
ith the Marylan or 28a-f show	≥ T	10a. State 10b. County OET, AWARE SU	SSEX		Toc. City	SEAF							1 X Yes 2 □ No
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E, Nid 1 and 2 s Health ar Iem 27 Is		STEVEN D.	MAYER	SO	N	530 1	NYLON B	LVD.S	SEAFOR	RD, D	ELAWA	RE 1	19973
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this ald di	2	1 Yes 2 No 27. Manner of Death		1	Satient 2	28b. Time of					lence 6 🗆 Ot		city)
	tion	1 ENatural 5 ☐ Pend	ding stigation	(Month,	Injury Day Year)	Injury	Wo	rk?]Yes 2.□			,,		
DIVISION I or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could	d not be	a. Place of	of Injury - At ho	ome, farm, st	reet, factory, office		28f.	Location (S	Street and Num	ber or Ru	ıral Route Number,
DIV Bire Jin by	erti	4 - Homicide deter	illiled	building	g, etc. (Specif)	/)				City or Ton	m, State)		
DIVISION To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director:	edical C		al Examiner: O		is of examina		th occurred at the ti nvestigation, in my o						
o the ithin ;	Mec	20h Signature and title of cortif					29c. Licens	se number			29d. Date sign	ed (Monti	n, Day, Year)
F 3 F 8		29b. Signature and title of certifi					i	05/39	(6)		Ochah.	IUL	20011
10 P		30. Name and address of person	n who complet	ed cause	of death /Item	1 23a) (Type		07(2)	· /		October	/8/~	2004
1-W1		30. Name and address of person		ou cause	1415	(, /)/\//	S/ON ST	SALI	153414	_	10 HEO	4	
	ate	31. Date filed (Month, Day, Yea	1r)	32. Reg	gi y trar's Signa	ture	SION ST			1	. , - , 40		
Regist		31. Date filed (Month, Day, Yea	5 2004	×	Genera	1 /2	None.	ar					

			For State Pagistra				ent of I	Health and N	Mental Hy		200	, 31	5510
			Registrar 1. Decedent's Name (First, Middle, La	ast)					2. Date of De		L. 00	3. Time	of Death
	Physicia /Medic	al		OOMEY	M	UMFO 4b.		or Location of Death	Month Octobe	Day	Yeer 2004 County of Deal	1010	Ам
	Examin	er	ATLANTIC GENER		ΔΙ		BERL			I L	VORCES	STER	
	Funeral Director		5. Social Security Number 6.		e (In yrs. last bir		Inder 1 Year oths Days		8. Date of Bir (Month, Da Oct. 2	th y, Year)	9. Birt	hplace (State buntry) rvland	or Foreign
0			Usual Residence of Decedent						1000. 2	0, 20			
2 10	how		10a. State 10b. County		10c. City, Tow	n or Location	1					10d. Inside	City Limits as 2 1 No
2004 0 1010	death with the Maryland rms 23a or 28a-f show	Director	Maryland Worces	ter	Bishop					to aut			
00	vith th	Dire	10e. Street and Number			10	f. Zip Code 2181	27		iog. Citiz	en of What Co USA	untry?	
-	s 23	erai	13102 Worcester I	Highway	Ever in II S	13 Was I			necify Yes or No	D- 1	4. Race - Ame	rican Indian.	
5 - 2	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23a or 28a-1 show of other than "natural", or items 20a or 28a-1 shown; the Medical Examinat round be notified at	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅				Hispanic Origin? (S pan, Mexican, Puert	Rican, etc.)		Black, Whit		
036	urs a	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 U Y	es 21 No	Specity:			Specify: Bl	ack	
10- 10- 5-0036	72 ho	eted	15. Decedent's E (Specify only highest g	Education rade completed)	16a	. Decedent's (Give kind	Usual Occu of work done	pation during most of wor	king	16b. Kin	d of Business	Industry	
10	filed within 72 hours after Hygiene. Wher than "natural", or Ite ant, the Medical Examira	Completed	Elementary/Secondary (0-12)	College (1-4or 5		borer	OT use retire	ed)		Do	mestic		
9 70	filed v Hygie other t	ပိ	11 17. Father's Name (First, Middle, Las	it)	l la	porer		18. Mother's Nan	ne (First, Middle				
6+26 and	Mental Merked o	To Be	unknown					Rhod	a Toome	еу			
Jary 26+26	should be filed and Mental Hygid is marked other aumatic event, II	-	19a. Informant's Name/Relationship	(Type, Print)	196	o. Mailing Ad	dress (Stree	t and Number or Ru	ral Route Numb	er, City or	Town, State,	Zip Code)	
officer 1	D € 2 =		Wallace Handy/care	etaker				ster High					
Ser.	ges 1 ar t of Hea If item or other		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3	☐Removal from State		ry, cremator	y or other pla		Date		cation - City or		
im	Pages ment of ant: If it		`4 □Donation 5 □Other (Spec	eity)	St. Pa			Cem. 10/					MD
Mumford, 141 Baltimore,	permit. Pages Department of tell Important: If its any injury or of		21. Signatury of Juneral Service Lice	ensee	10.			ess of Facility 121			- Salis	-	
Σ.	2 □ E = 0		23a. Part1. Enter the disease, or con	dalication of the course	the ath Do			IEMORIAL				218 Approxim	
			shock, or heart failure. List onl	y one cause in each lir	ne.	,	i mode or dy	ing, scorr as caroliae	or respiratory o			Interval B Onset and	etween
	Physician /Medical		disease or condition resulting in death)	a. Musto or as	a consequence	of):							
4	Examiner	١.			A65	01).					10		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unegase or injury	Due to (or as	a consequence	of):							
	cuted	Examiner	that initiated events	c									
90,	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence	of):							
Box 68760,	0 % 0	dicai		d							-		
9 ×	ding	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of pregnancy					2	3d. Date of de	iverv	
	atten atten 1 for u	cian	23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 ☒ No	4□Pregnant at	2 Fetal death		pic pregnance or (specify) _	Э			Month	Day	Year
P.O.	t the c by the achec	hysi	9 Unknown	9□ Unknown									
Division of Vital Records, P	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	by	Part II. Other significant conditions	contributing to death b	ut not resulting	in the under	ying cause g	iven in Part I.			se contribute to		f death? Unknown
000	w require been si should I	Completed							24a. Was			utopsy finding	
Re	The lay te has age 2	mo				_			auto perfe	ormed2 2 X No	death?	completion of 2 \(\subseteq \text{No} \)	cause or
ita	ician: The lav certificate has rector, page 2	BeC	25. Was case referred to medical					26. Place of Dea					
>	Physician: this certific ral director,	To	examiner? 1 □ Yes 2 No		ent 2 ER/O	utpatient 3	DOA		lome 5 ☐ Res			cify)	
n o	ding P. h. After t	on:	27. Manyrér of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Yeer) 28b.	Time of Injury		ork?	28d. Describe	how injury	occurred		
isio	ttend death stor: /	Certification:	2 Accident investigat 3 Suicide 6 Could not	be 300 Block of Ini	iury - At home, f	arm street f	-]Yes 2□No	28f. Location	Street and	d Number or R	ural Route Nu	umber.
Div	after after Direction by	ertif	4 Homicide determine	building, et	c. (Specify)	aiii, siieei, i	actory, office	'		wn, State)		3147710010111	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	(Check only 2 Medicel Ex	Physician: To the best aminer: On the basis o	f examination a								(s)
	thin 2 the omple	Med	one) 29b. Signature and title of certifie	and manner st	ated.		29c. Licen	se number		29d. Date	signed (Mont	h, Day, Year,)
	8 4 4 4		11/1	140			02	7898		10	- 22	-OU	
			30. Name and address of person Mr.	o completed cause of c		(Type Print)	TR98 RVE;	RFR (11	6n2	1811	
-			31. Date filed (Month, Day, Year)	2 KW / /	1.D. 310 Par's Signature	V IM	INKUL	KUC;	pur	(10)	(11)	- '(·
	St Regist	ate	OCT 2 5	5 2004	epera	B	Apa	KS					

tment of Health and Meni ificate of Death	Reg. No.	300	1 /
tment of Health and Men	tal Hygiene no.	355	17

		•	For State Registrar	State of M	aryland / Dep $C\epsilon$	ertificate of	lealth and N <i>Death</i>		en2004	35517
			Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medic		KENNETH GORDON	MASTERM	AN			10	10 200	31 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Examin		4a. Facility Name (If not institution, give stre	et and number)	-11	4b. City, Town, o	or Location of Death		4c. County of De	ath
			The Memoria, 5. Social Security Number 6. Sex	I HOS	PITAL	If Under 1 Year	If Under 24 Hrs.	O Date of Birth	TAIR	70 <i>†</i>
	Funeral Director		5. Social Security Number 6. Sex	2□F 7. A	je (In yrs. last birthda) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		Sirthplace (State or Foreign Country)
			Usual Residence of Decedent		04			MAR 12 1	1920 M	ASS.
	larylan show	_	10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	the Ma 28e-f a	cto	MD CAROLINE		DENT					1X Yes 2 □ No
	€ 9 €	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (
I	ter death w	eral	410 COLONIAL DRIVE 11. Marital Status 12.	Was Decedent	Ever in U.S. 13		629 dispanic Origin? (Sc	ecify Yes or No-	USA 14. Bace - Arr	nerican Indian,
e	036 ours after d et', or Iten Exercirer	Fun	1 Never Married Married	Armed Forces? 1 ☐ Yes 2 🔯	No	. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, Wh	hite, etc.
ienne+	DO30	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2Ã No	Specify:		Specify: W	HITE
15	5-C	Completed	15. Decedent's Educat (Specify only highest grade of	ion o <i>mpleted)</i>	(Giv	edent's Usual Occup re kind of work done	during most of work	ding 10	6b. Kind of Busines	s/Industry
-	2121 d within giene. r than	ם	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired	d)		EU/MORT T	G) (
₹	Hygi httper	ပိ	17. Father's Name (First, Middle, Last)	4	<u>t M</u>	INISTER	18. Mother's Nam	e (First, Middle, Ma	EVANGELI aiden Sumame)	SM
7	# 7 a b e	To Be	GEORGE HENRY EDWARD	MASTERI	MAN		EVA BR	OOKS		
ERMAN	re, Maryla s 1 and 2 should f Health and Men tiem 27 is marke other treumatic		19a. Informant's Name/Relationship (Type,	Print)	19b. Mai	ling Address (Street	and Number or Rui	ral Route Number,	City or Town, State	, Zip Code)
W	and 2 and 2 ealth 3 m 27 i	18	SAUNDRA J. GRIFFIN	/DAUGHT		O GOLDSBO	ROUGH ST.			
7	0 0		20a. Method of Disposition 1	oval from State	20b. Place of Disp cemetery, cr	position (Name of ematory or other place		Date 20	0c. Location - City of	or Town, State
#	Baltimo		' 4 □ Donation 5 □ Other (Specify)			CEMETERY		6-2004	OXFORD, M	ARYLAND
2	Balt permit. Depart import any inj		21. Signature of Funeral Service Licensee	E 0	_ \ F	22. Name and Addre ELLOWS, H]	ELFENBEIN	& NEWNAM	1 FUNERAL	HOME PA
	Executed 1		23a. Part1. Enter the disease, or complicat	tions that cause	d the death. Do not e	00 S. HARI	RISON ST.	EASTON,	MD 21601	Approximate
	Observatore		shock, or heart failure. List only one of Immediate Cause (Final	cause on each I	ine.	- 4 - 1	,	,,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (dras	a consequence of:	Neumo-	11/9			
	Examiner		w	Hune	okalen	a ia				
		ner	Gagus tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dustras	a consequence of):					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Puo to /or or	s a consequence of):					
	60, the executed sician and burial-transit			Due to (or as	a consequence on:					1
	68760, ficate be ex physician is the burial	edlcal	d							
	Box 6 eath certifi attending	N/M	IF FEMALE: 23b. Was decedent pregnant	If yes, outcome					23d. Date of d	Jelivery
	Geath death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		☐ Ectopic pregnancy ☐ Other (specify)	у		Month	Day Year
	IS, P.O. I	Physician/M	9 Unknown	9□ Unknown						
	S, F es that igned be de	by	Part II. Dther significant conditions contri	14	but not resulting in the	underlying cause giv	ven in Part I.			to the cause of death?
	cord w requir been si should	Completed	cerebral shoke	(2) 70	+ malely 1	1919		1 🗆 Yes	s 2 □ No 3 □ I	Probably 4 \(\square\)Unknown
	e 2 st	nple			•			24a. Was an autopsy perform	prior to	autopsy findings available o completion of cause of
	The The icate								No 1 ☐ Ye	es 2□No
	of Vital Rec nysicien: The law nis certificate has b I director, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 227No Hos	pital:	ient 2 ☐ ER/Outpati	ont actions Off	200	th (Check only one	,	
	on of ding Phy h. After this funeral d	-	27. Manner of Death	28a. Date of Inj (Month, Da		of 28c. Injur	A CONTRACTOR OF THE PARTY OF TH	28d. Describe how	nce 6 Other (Sp w injury occurred	эвспу)
	Division of Vital Records, to a standing Physicien: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Di	ay Year) Injury		rk?]Yes 2 ☐ No			
	VIS r Atte	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	njury - At home, farm, : htc. <i>(Specify)</i>	street, factory, office		28f. Location (Stre	et and Number or I State)	Rural Route Number,
	Urs aft							li		
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier Certifying Physic (Check only 2 Medical Examiner one)	ian: To the best r: On the basis and manner s	of examination and/or	ath occurred at the til investigation, in my o	me, date and place, opinion, death occur	and due to the cau rred at the time, dat	use(s) and manner a are and place, and dr	as stated. ue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1		29c. Licens			d. Date signed (Mor	,
			Weigh Son	/ V	no	Dø	105976	2	1011110	٣
			30. Name and address of person who com	•						
			HAIDER SARRAF M.D.	219 S.	WASHINGTO	N ST., EAS	STON, MD_	21601		

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 35519 Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) AKA ELSIE JANET 2. Date of Death 3. Time of Death Month Year **Physician** ELSIE MITCHELL MITCHELL 9:05 AM 10 22 2004 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENSINGTON NURSING HOME KENSINGTON MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Sept. 3, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2점F 98 Yrs. Pennsylvania Director 224-92-3631 Usual Residence of Decedent the Marylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al', or items 23a or 28a-f sho Examiner must be nutified at 1 ☐ Yes 2 1 No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 end 2 should be filled within 72 hours after death with sent of Health end Mentel Hygiena. Int: If Item 27 is marked other then "netural", or Items 23a or 2925 Faulkner Place 20895 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: ð 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Boardman Fortney Katherine Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James I. Mitchell/ Son 2925 Faulkner Place, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Oct. 30, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ò Addison Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2004 Addison, Pennsylvania 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Hames 23a. Part1. Inter the disease, or complications that saysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) URINARY TRACT INFECTION MONTH Examiner Examiner The law requires that the deeth certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical



Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other	significant conditions conti	ibuting to dea	ath but not resulting in the underlying cause given in Part I.
(i)	Anopexia	(2)	dehydration

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown

1 Tes 2 10 o

(3) 4/0 CVA (4) Impaired hearing

a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25.	Was case examiner?	referred to medical
27.	Manna of	Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Lursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27.	Manner of Death	
	1 Matural	5 Pend
	2 Accident	inves

28a. Date of Injury (Month, Day Year) ding stigation 6 ☐ Could not be determined

28c. Injury at Work?

D43121

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10/22/2004

4 Homicide

3 Suicide

Certification: To Be Completed by

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

294.	Cettille
	(Check or
	one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number

D

Hospital or Attending Physics 4 hours efter deeth.
 Funeral Director: After this eletaly filled in by the funeral di

To the Hospital of within 24 hours e To the Funeral D

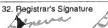
Aftar this

chow dly, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NURUL CHOWDHURY, MD; 5/4/

KING CHARLES WAY; BETHESDA, MD20814

State Registrar

31. Date filed (Month, Day, Year) OCT 25 2004



		1- For State of M	laryland / Depa	artment of Health and Nartificate of Death	Mental Hygie	•
Physi /Med Exam	lical	Decedent's Name (First, Middle, Last) Francis Virg: 4a. Facility Name (If not institution, give street and number Southern Maryland Hospit	7)	II 4b. City, Town, or Location of Death Clinton	October	Day Year 24, 2004 4:05PM M 4c. County of Death Prince George's
Funera Directo		5. Social Security Number 5. Social Security Number 6. Sex 7. A The security Number of December to the security Number of December 1. A December	nge (In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 14,	9. Birthplace (State or Foreign Country)
Dattilliore, Mary farting A. I.A. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at	To Be Completed by Funeral Director	Maryland Prince George's	t Ever in U.S. 13. 13. 13. 13. 13. 13. 13. 13. 13. 13	10f. Zip Code 20735 Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto II — Yes 2 1 No Specify: dent's Usual Occupation More during most of work and of work done during most of work CO NOT use retired) chant 18. Mother's Nam Jane The Specify of the Specify: 19. Address (Street and Number or Rull Old Branch Avenue Sistion (Name of Inatory or other place) tion Cemetery 20	pecity Yes or No- Prican, etc.) In the Company of	ity or Town, State, Zip Code) 1, Maryland 20735 2. Location - City or Town, State Clinton, Maryland
Physician /Medica Examine	n al	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Automatical Modern Cause (Disease or injury that initiated events	ed the death. Do not ent line.	2. Name and Address of Facility Lee	a Ferry Ro or respiratory arrest,	pad Clinton, MD20735 Approximate Interval Between
The Cords, P.O. BOX of The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Be Completed by Physician/Medic	Part II. Other significant conditions contributing to death ACUTE RESULT F	2 Fetal death 3 at time of death 5	26. Place of Deal	23e. Did tobac 1 Yes 24a. Was an autopsy performed 1 Yes 2 th (Check only one)	24b. Were autopsy findings available prior to completion of cause of death?
DIVISION OF VICA To the Hospital or Attanding Physician: To the Hospital or Attanding Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical Certification; To	1 Yes 2 No Hospital: 1 Napati 27. Manner of Death 1 Natural 5 Pending (Month, Direction) 1 No	jury lay Year) 28b. Time of Injury njury - At home, farm, stretc. (Specify) st of my knowledge, death of examination and/or in	28c. Injury at Work? M 1 Yes 2 No eet, factory, office	28d. Describe how in 28d. Location (Stree City or Town, Street City or T	it and Number or Rural Route Number, tate)
DBb	State	39. Signature and title of certifier 30. Name and address of person who completed cause of person who cau	death (Item 23a) (Type, 2010 (Octoors) (Contrar's Signature)	29c. License number D - 1854. Print) UNE CENTE		Date signed (Month, Day, Year) TOBER 25, 2004 DONF, U.S. 2004

State of Maryland / Department of Health and Mental Hygien 2004 35521 Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1 Decedent's Name (First, Middle, Last) Day Vear Month **Physician** Nomikos Andrew 23, 2004 4c. County of Death CTOBER 2:41p. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CALVERT RT.260 west of HARRISON BLVD NORTH BEACH If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 3, 13 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1⊠M 2□F 55 1949 Yrs. Washington, DC 219-56-0752 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County 10a State or 28a-f show Examiner must be notified at 1 XYes 2 ☐ No MD Calvert North Beach Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 20714 8813 Dayton Avenue 238 Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 No filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: White δ 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) Self Employed Painting Contractor other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othnany injury or other traumatic evant <u>once.</u> Be Cheakalos Spiro Nomikos Demetra Peter 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8813 Dayton Avenue North Beach, MD Patricia Nomikos (wife) 20b. Place of Disposition (Name of cemetery, criffed of Chiff placements) 20c Location - City or Town, State 20a. Method of Disposition Oct 28 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sts. Constantine & 2004 Annapolis, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Juneral Service Licensee 8125 Southern Maryland Blvd Owings, MD 20736 Goff Çary 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) THIURUS MULTIPLE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 □Unknown cate has been sig Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check onl one examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{\text{Y}}\) ther (Specify) SCENE 1X Yes 2 □ No Certification: To this 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) OBJECT (5 1 Natural 5 Pending investigation DRIVER OFER RIMPLET IN MHTIXED 10-23-04 2:418 1 ☐ Yes 2 ☐ No death. 2 Accident after deatl Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide in 24 hour. the Funeral Directory in filled in RTZ60W.of HOMISON RUDCOLVERTG 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. OCTOBER 24,2004 Minue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar SOREU

32. Registra Signature 6 2004

	_	For Stata Registrar		,	Ce	rtifica	te of L	ealth and Death			ag. No.	200	4	355
nysicia	an	Decedent's Name (First, Middle, La	st)							Date of Deat	th Day	Ye	ar /	3. Time of Dea
Medic	al	CUBA J. O'NEAL								ctober		200		0820
xamin	er	4a. Facility Name (If not institution, give		nber)		1		Location of Dea	th		-	County of D		- 0
			NERAL	HOSPI	TAL		MBR er 1 Year	TDGE If Under 24 Hrs		D (D')	12	RCHE		
neral ector		235-30-/196	M 2□F	7. Age (In yrs. 79	Yrs.	Months		Hours Min	00	Date of Birth Month, Day, LT 29	192		Country)	e (State or For TRGINI
	}	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d.	Inside City Lin
8 pg	5	MD MIT DO	.m											TX☐Yes 2☐
event, the Medical Examiner must be notified at	Funeral Director	MD TALBO	1		IRA	PPE 10f. Zi	p Code			1	0a. Citi:	zen of What	Country	7
1 P	0	3773 SEYMOUR DE	TVE				2167	2			-3	USA		
9	era	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.	Was Dece		spanic Origin? (S n, Mexican, Puer	Specify	Yes or No-		14. Race - A		
	Ď	1 ☐ Never Married ZX Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 Yes If Yes, Giv Year or Da	2 □ No 'e		lf Yes, spe 1 □ Yes		s, Mexican, Puer Specify:	rto Rica	n, etc.)		Black, W Specify: \(\bar{V}\)	/hite, etc. √HITE	
	Completed	15. Decedent's E (Specify only highest gr	ade completed)		16a. Dece (Give life.	dent's Usu kind of we DO NOT L	ual Occupa ork done d use retired)	tion uring most of wo	orking		16b. Kir	nd of Busine	ss/Indus	try
1	E	Elementary/Secondary (0-12)	College (1	-40r 5+)			TRICI				C	OAL MI	ואדאמ	2
) H	Bec	17. Father's Name (First, Middle, Last)		,			18. Mother's Na	me (Fi	st, Middle, I				
9	ToB	LANTIE O'NEAL						NELL	IE 3	RANSOM	Į.			
othar traumatic		19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Addres	s (Street a	nd Number or R	ural Ro	ute Number	, City or	Town, Stat	e, <i>Zip C</i> o	de)
ar tra		MARY A. O'NEAL/W	IIFE		3773	SEY	MOUR	DRIVE,	TRA	PPE, M	LARY	LAND 2	21673	3
		20a. Method of Disposition			Place of Dispo	sition (Na	me of)	Date		20c. Lo	cation - City	or Town,	State
ry or		Y Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		State	VETERA	•			12-	2004	HIIR	LOCK,	MARY	ZT.AND
injury 9.		21. Signature of Funeral Service Lice		1110	22	2. Name a	nd Addres	s of Facility						
once.		12111 3	n 5 21	CERO) FE	LLLOW	S, HE	LFENBEI ISON ST	N &	NEWNA	M F	UNERAI 21601	L HOM	IE PA
		23a. Part 1. Enter the disease, or con	plications that c	aused the dea								21001	Ap	proximate
ian		shock, or heart failure. List only Immediate Cause (Final			2 2 2								Or	erval Betweer set and Deat
cal		disease or condition resulting in death)		or as a conse									14	reek
ıer				inari		11 07	4	in fect	10				114	veer
	ē	Sequentially list conditions, if any, leading to immediate		or as a conse		201			,	/				
Dollar Caller	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C											
3	Exa	resulting in death) Last	Due to (or as a consec	quence of):									
<u> </u>	cai	(d											
as tu														
esn	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			Texasia -					2	3d. Date of	delivery	
detached for use as th	İcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	irth 2□Feta ant at time of o		Other (s	pecify)					Month	Day	y Year
	hys	9 □ Unknown	9□ Unkna	own										
ep eq	by P	Part II. Other significant conditions	1	4		nderlying	cause give	n in Part I.		23e. Did tob	oacco u	se contribute	e to the c	ause of death
Should	ed	Parkinson	15 C	15025	4					1 🗌 Ye	s 2[□ No 3 □	Probably	/ 4U⊒Unkn
2	Completed									24a. Was a		24b. Were	autopsy	lindings avail
age 2	mo								İ	autops perform	ned?	death	1?	etion of cause
J		25. Was case referred to medical						26. Place of De		1 Yes 2		101	′es 2□	I NO
	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	mpatient 2	ER/Outpatier	nt 3 🗆 D	Othe					Other (6	Sanaif ()	
	T:T	27. Manner of Death	28a. Date	of Injury	28b. Time o		28c. Injury Work			Describe ho			рөспу)	
	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		th, Day Year)	Injury	м		? 'es 2 □ N <i>o</i>						
i i	ifica	3 Suicide 6 Could not to determined	289. Place	of Injury - At h	nome, larm, str	eet, factor	ry, office		28f.	Location (St.	reet and	d Number or	Rural Ro	oute Number,
<u>⊆</u>	Ser.	TOMICOS	Dallar	ng, etc."(<i>Speci</i>	'Y')					City of 70Wi	, Siale)			
completely titled in by the funeral director, page	Medical Certification:	29a. Certifier 1 Cartifying P (Check only one)	minar: On the ba	best of my kn asis of examin- ner stated.	owledge, deat ation and/or in	h occurred vestigation	at the time n, in my op	e, date and place inion, death occ	e, and a	due to the ca t the time, da	ause(s) ate and	and manner place, and o	as stated	d. cause(s)
completely fitled in by the	Me	29b. Signature and title of certifier				29	c. License	number	-	2:	9d. Date	signed (Me	onth, Day	(Year)
٥		Dan an sa					Hon	number 59973 mbrid			10	1g/ni	1	•
		20 H	nomeleted ::	o of death (tr	m 02c\ /T =	Deic ()	100	27415)		101	7/0	7	
				eti) diseb to e	m 238) (TVD8.	rrint)								
		30. Name and address of person who	Completed cads	ON R.	son hi	. C+	1	lawil		m	2 -	11	, -	

State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** Lawrence Xavier Odum Oct. 2004 7:10 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13912 Dowlais Drive Rockville Montgomery

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X**] M 2□ F Months Days Hours 579-38-5165 78 Director July 10, 1926 Maryland Usual Residence of Deceden filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State r than "natural", or Itams 23s or 28s-f show the Medical Examiner must be notified at No 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13912 Dowlais Drive 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If itam 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) 8+ Accountant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Burleigh Odum Anna Mae King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13912 Dowlais Drive, Rockville MD 20853 Mary L. Odum (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ö Arlington Natl Cem. 11/3/2004 Arlington, VA permit. Pag Department Important: I any injury o * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature & Funeral Service Licensee 9013 Annapolis Road, Lanham MD 20706 compations that caused the death, one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part1 Enter the disease, or conshe k, or heart failure. List Imm diate Cause (Final **Physician** di ease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under ing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Phyaician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Be Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year be detached for 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing death but not resulting in the un 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 🗆 🔭 Yes 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check examiner? Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Desidence 6 □Other (Specify) 2 28a. Date of Injury (Month, Day Year) Manner of ath 28h Time of 28c. Injury at Work? 28d. Lascribe how injury occurred Certification: After or Attanding 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Accident Accident after death Director: the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and play, and due to the cause(s) and manner stated. 29d. Date signed (Month) Day, Year 29b. Signature and title of 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		- For				Depa	artment of	Health	and N	Mental Hyg	_	04	255	01
		- State Registrar				Ce	rtificate c	of Death	7		ag. No.	UH	355	
Physicia	an	Decedent's Name (First, Middle Erma Lee Pa								2. Date of Dea Month	Day	Year	3. Time of D	
/Medic	al .			umbasl			4b. City, Town	ar Looption	of Dooth	NOVEMBE		2004	2330	M
Examin	er	4a. Facility Name (If not institution) MEMORIAL HOSE		umb u r)			7.	BERLAN			4c. County	LEGAL		
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last bi	rthday)	If Under 1 Ye	ar If Unde	r 24 Hrs.	8. Date of Birth				Foreign
Director		234-48-8640	1□M 25 F	8	1	Yrs.	Months Da	ys Hours	Min.	8. Date of Birth (Month, Day June 30	,1923	Co	hplace (State or untry) WV	
p ,		Usuel Residence of Decedent 10a. State 10b. County			10c. City, Tow								40.1.1.1.0	11. 11
shov	2		- 1				Cation						10d. Inside City	
the M	Director	WV Miner	aı		Keyse	5T	10f. Zip Cod			1	0g. Citizen of	What Co		
With Ba or	<u> </u>	59 James Stree	et.				267				U.S.		unity i	
death ms 2;	Funerai	11. Marital Status	12. Was De	cedent E	ver in U.S.	13.			rigin? (Sp	pecify Yes or No-	14. Rad	ce - Ame	rican Indian,	
or its	Ē	1 ☐ Never Married 2 ☐ Marri	Armed F ed 1 ☐ Yes	-orces? 2 ⊊ No Sive	0		ii Yes, speciny C 1 ⊟ Yes 2 1 XII			Hican, etc.)		ck, White	e, etc.	
DO3	d by	3 XWidowed 4 ☐ Divorced	Year or	Dates:					y .		Specif	whi		
72 h	Completed	15. Decedent (Specify only highes		1)	16a	(Give	dent's Usual Oc kind of work do DO NOT use re	ne durina ma	st of work	king	16b. Kind of B	usiness/	Industry	
within than than	dmo	Elementary/Secondary (0-12)	College	(1-4or 5+	+)								h-a-1-	
Hygi Hygi	0	17. Father's Name (First, Middle, I	_ast)				afeteri			e (First, Middle, I	public Maiden Suman		10015	
yland 21215-0036 Ould be filed within 72 hours after death with the Maryland Mantal Hygiene. arked other than "naturel; or itams 23a or 28a-f show atte event, the Mudical Exertine chart be notified at	To B	Hubert S. Hart	man, Sr.					Li	111ia	n W. Whi	teman			
ary		19a. Informant's Name/Relationsh					-			ral Route Number			lip Code)	
and 2		Debbie Hoover/	daughter	•			1/2			Keyser,				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all popurment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or any injury or other treumatic event. The Madical Exercipance.		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		n State			sition (Name of matory or other Memorial				20c. Location : Keyser ;			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or itams 23a or 28a-1 show any injury or other treumatic event, the Marical Extracting to motified at once.		21. Signature of Funeral Service I	Licensee	, ,	-2/	N	2. Name and Ad	Funer	al H	ome, Inc				
		23a. Part1. Enter the disease, or	complications that	caused t	the death. Do					er, WV 2 or respiratory arre			Approximate	
Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line	- 51		1						Interval Betwee	en ath
/Medical		disease or condition resulting in death)	a. Due to	o (or as a	consequence	of):	K						4 days	
Examiner		Convenients list on a Mines	, Un	kno	wn!	ET	iologi	i					loday	>
/ p =	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a	consequence	of):	0.00	v						
and -trans	Examiner	that initiated events resulting in death) Last	C. Dung	200	consequence	C (opeen	vised	t 1	lost			Tyrs.	
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687 tiflicate ig phys as the	-		d											
Box 68'	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o				-				23d. Da	te of deli	very	
Geath death of for	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pre	gnant at t	2 □ Fetal death ime of death		Ectopic pregna Other (specify				Mo	onth	Day Ye	ar
P.O. I	hys	9 🗆 Unknown	9□ Unk	nown										
dS, F	by F	Part II. Other significant condition	_		_			-	I.				the cause of dea	
cord w requir been si	ted	Chronic Reno	u back	ire	1 HYP	er.	tensic	2		1 □ Ye	s 2 % No	3 🗆 Pro	obably 4 Uni	known
Division of Vital Records, P.O. Box 68 in a variending Physician: The law requires that the death certifica after death. Director: After this certificate has been signed by the attending ph in by the funeral director, page 2 should be detached for use as the content of the c	Completed by Physician/Med	Rheumatoic	L Arti	041.	tis					24a. Was a autops	y	prior to c	topsy findings av	ailable ise of
f Vital Ry	Con									perform 1 Yes 2		death? 1 🗌 Yes	2□ No	
Vital F	Be	25. Was case referred to medical examiner?	Hospital:							h (Check only on				
Of Phys	7	1 Yes 2 No	28a. Date	Inpatien		utpatier Time o		njury at	lursing Ho	ome 5 Reside			city)	
On ding th. After	tion	1 Natural 5 Pending	g (Mo	nth, Day		Injury	\	Vork? ☐ Yes 2[]No					
Vision O' Attending Ph er death. ector: After th by the funeral	ifica	3 ☐ Suicide 6 ☐ Could r	not be 28e. Plan			arm, sti	eet, factory, offi			28f. Location (St.		er or Ru	ral Route Numbe	≥ <i>r</i> ,
S affe	Certification:	4 Homicide	DUil	aing, etc.	(Specify)					City or Town	, State)			
Division (To the Hospital or Attending Is within 24 hours after death.) To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physicien: To the	ne best of	f my knowledg	e, deat	n occurred at the	time, date a	and place,	and due to the ca	iuse(s) and ma	anner as	stated.	
To the H within 24 To the F complete	Medi	one)	and ma	inner stat	ed.									
To To	4	29b. Signature and title of certifier	. 11					ense number			d. Date signe		/	
			nji/hen			7		9318		NO	OVEMBER	510	2004	
9		30. Name and address of person of DR. N. RANJITHAN	who completed ca 517 OLD				Print) MBERLANI),MARV	[,AND	21502				
Sta	te	31. Date filed (Month, Day, Year)		Registra	r's Signature		11 000	- 1	a.	21302				
Registr	1.40	NOV 0 9	2004	March.	12-3/	G	Lose	Cal.	-					

	For	State of Mary				ygiene	
	1 - Stete Registrar		Cer	tificate of	Death	Reg. Na UU	4 35525
Physician /Medical Examiner	Anthony .	5 Pelles	PLIND	4b. City, Town, o	Month 1.0	Day 200	
Funeral Director	22960 McDani 5. Social Security Number 156-01-0929 Usuel Residence of Decedent 10a. State 10b. County	6. Sex 1 X 2 F 7. Age (In 85	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of E Hours Min. (Month, I	Birth Day, Year)	D. Birthplace (State or Foreign Country) 10d. Inside City Limits
with the Mary	MD Talb			10f. Zip Code 21647		10g. Citizen of Wh	1 ☐ Yes 2☐ No
urs after death	3√2 Widowed 4 □ Divorced	Armed Forces? ied 1,	II	I□Yes 2☐XNo	Specify:		American Indian, White, etc. White
within 72 ho iene. then "natur tre Mudical	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	t's Education US transfer grade completed) College (1-4or 5+)			ation during most of working d)		Electric
	17. Father's Name (First, Middle, Michael Pel	legrino			Rose Zuppa		
ages 1 and 2 sho ant of Health and it: If item 27 is m y or other treum	Michelle Pe 20a. Method of Disposition 1□ Burial 2□ Cremation	llegrino Hec	gadoru 20b. Place of Dispo cemetery, crei	22960 I sition (Name of natory or other plan	McDaniel Farm	Ln , McDa 20c. Location - C	21647 aaniel MD ity or Town, Stele
permit. P Departme Importen any injur.	21. Signature of Funeral Service	all the	hun	R. Carr	oll Hurley Fu	neral Ho	ome,PC
Physician /Medical	23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	vascular			HARETS, I	2Ab/tioDmate Interval Between Onset and Death
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumstic event, the Mexical Exacting Frankling of the page of	Physician /Medical Examiner 1. Decedent's Name (First, Middle A Facility Name (If not in stitution 22960 McDani 5. Social Security Number 15. Social Security Number 15. Social Security Number 10a. State 10b. County 10a. State 10b. County 10a. State 10b. County 11b. Marital Status 1 Never Married 2 Married 15. Decedent 11c. Marital Status 1 Never Married 2 Married 15. Decedent 17c. Father's Name (First, Middle, 17c. Father's Name (Physician //Medical Examiner 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not in fittution, give street and number) 22960 McDaniel Farm Lane 22960 McDaniel Farm Lane 5. Social Security Number 156-01-0929 156-01-0929 1585 156-01-0929 1585 1585 1585 1585 1585 1685 1786 1885 1885 1985	Physician //Medical Examiner I. Decedent's Name (First, Middle, Last) An Hoon J Pellogrimb 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4a. Facility Name (If not infittution, give street and number) 4b. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 10c. City, Town or Lo McDanie 10c. City, Town or Lo McDanie 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Yet Yes, Give WW II 14. Marital Status 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Farm Lane 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Yes 2 No If Yes, Give WW II 19. Mach. 19. Mach. 19. Mach. 19. Mach. 19. Mach. 19. Mach. 20. Place of Disposition 19. Mach. 20a. Method of Disposition 19. Mach. 21. Signature of Funeral Service Licensee 22a. Paft. Enter the disease, or complication strat caused the death. Qo not enter	Physician Physic	Physician Physician The ph	Physician (Medical Examiner) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day (Month Day 1.0

been signed by the attending physician and should be detached for use as the burial-transit

s certificate has b

this

within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral

To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine

Physician/Medical

Completed by

Be

Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Interval Between Onset and Death Hyperten sion Due to (or as a consequence of): Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 9□ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Year Dav

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 **X**No 3 Probably 4 Unknown

21647

insafficience

24a. Was an autopsy 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes No

2 ER/Outpatient 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work?

28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 | Homicide

5 Pending investigation 6 Could not be determined

Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

- ASTUN

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 042816

Dr.

29d. Date signed (Month, Day, Year) 104 20/

21601

Name and address of person was completed cause of death (Item 23a) (Type, Print) m Burgoyne

555 Cynwood

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

			1- For State of Maryland	/ Depa	artment of H	lealth ar Death		giene2 () Reg. No.	104	35526
			Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death
	Physici		Albert George Phillips, Jr.				Octobe:	r 25,200	Year)4	10:30 A M
)	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of		4c. County		120.00 12
			Anne Arundel Medical Center		Anna	polis		Anne	Aru	nde1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir Min. (Month, Da	th V Year)	9. Birthp	lace (State or Foreign
	Director		135-20-7735 ¥□ M 2□ F 76	Yrs.	Worth's Days	riouis	April	18,1928	Conne	ecticut
	p v		Usual Residence of Decedent 10a. State 10b. County 10c. City.	Town or Lo	nation				1.	0d. Inside City Limits
	larylan show	ក		fton	ocation					1 ☐ Yes 2 ☐XNo
	28a-f	ect	10e. Street and Number	LLOII	10f. Zip Code			10g. Citizen of	What Cour	
	a or	۵	1709 Crofton Parkway			1 /			what Coun	nry?
	s 23	era	11. Marital Status 12. Was Decedent Ever in U.S.	13	211		2 (Specify Vos or No	USA 14 Bac	ce - Americ	an Indian
98	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23e or 28e-f show deter than "natural", or items 23e or 28e-f show event. I've Medical Exartirat must be rolling at	y Funeral Directo	1 Never Married 2 Married 1 Yes 2 Mool If Yes, 2 Who		If Yes, specify Cuba	n, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	Bla Specif	ck, White,	etc.
Ö	hour:	Completed by		160 Dasa	death Havel Occur			401 16:-4 -4 1		4
15	n 72	jet	(Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most o	f working	16b. Kind of B	usiness/inc	dustry
12	withi iene. than	E	Elementary/Secondary (0-12) College (1-4or 5+)	Claim.				Aetna I	nsura	ince
D	Hygic other ent,	Be C	17. Father's Name (First, Middle, Last)				Name (First, Middle,	Maiden Suman	ne)	
an	Med ic ev	To B	Albert George Phillips, Sr.			Lotil	la Enswort	h		
Maryland 21215-0036	12 should be finance and Mental His marked of raumatic eve	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailie	ng Address (Street	and Number	or Rural Route Numbe	er, City or Town,	State, Zip	Code)
Σ,	0 = 12 =		Elizabeth P. Edelen (daughter)	16 I:	ndependen	ce Dr.	New Freed	lom, PA.	1734	.9
ore.	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	ce of Disponetery, crei	sition (Name of matory or other place	e)	Date	20c. Location -	- City or To	wn, State
<u>Ĕ</u>	nit. Page partment o ortant: If injury or		'4 Donation 5 Other (Specify)				1/06/2004			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee				Beall Fune			
_	20 E = 9		Beverly Ball				y. Bowie,		d 20	715
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	g, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition							Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conseque	nce of): ^						
	Examinio	۰	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque		ia					
	led Isit	Examiner	if any, leading to immediate cause. Enter Inderlying Cause, Disease or injury	ilde Oi).						
	xecul and al-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence)	nce of):						
8760,	cate be executed bhysician and the burial-transit	a E		,						
687	ficate physis the	edicai	d							
Вох	eath certifi attending I for use as	N/W	IF FEMALE: 23b. Was decedent pregnant 23c. Il yes, outcome of pregnance					23d. Da	te of delive	rv
ĕ	death atte	ciai	in the past 12 months? 1 ☐ Ves 2 ☐ No 1 ☐ Ves 2 ☐ No		Ectopic pregnancy Other (specify)					Day Year
O.	that the d ed by the detached	Physician/M	9 Unknown							
٥,	The law requires that the death certificate be executed tte has been signed by the attending physician and otge 2 should be detached for use as the burial-transit	by P	Part II. Other significent conditions contributing to death but not result	ng in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use cont	nbute to th	e cause of death?
rd	w require been sig should b	edt	Ischemic bowel				101	res 2 ☐ No	3 🗆 Proba	ably 4 Unknown
O O	aw re	piet	Rengil Failure				24a. Was	an 24b.	Were autop	esy findings available appletion of cause of
æ	The lay	Completed	H F F				— autop perfo 1 ☐ Yes	rmed2 c	prior to con death? 1 □ Yes	
Vital Records,	ysician: The is certificate hadirector, page	Bec	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·	26. Place of	Death (Check only o			
of V	Physician: this certific ral director,	Jo.	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 EF	R/Outpatien	nt 3□ DOA Othe	er: 4 🗌 Nursi	ng Home 5 ☐ Resid	ience 6 □Oth	er (Specify)
0	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day Year) 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	8b. Time of Injury	28c. Injury Work	at c?	28d. Describe h	now injury occurr	red	
Sio	Attending it death. ector: After by the fune	cati	2 Accident investigation		M 1 []	Yes 2 □ No				
Division	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, lactory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
נו	Hospital		29a. Certifier 12 Certifying Physician: To the best of my knowle	edac desil	n nonlimed at the co	no dete	logo and due to the			
		Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and manner stated.	n and/or in	vestigation, in my op	pinion, death	occurred at the time,	date and place,	and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License	number		29d. Date signed	d (Month, L	Day, Year)
	7		Chan of MO		DS	51	78	10/2	51/2	4
D	(10)		30. Name and address of person with completed cause of death (Item 2	3a) (Type,	Rrint)	N	1 0	1		0
			31. Date lited (Month, Day, Year) 32 Registrar's Signatur		June	Hru	nde/	ledic	ca)	Lork
	Sta Regist		OCT 2 7 2004	1	2					

		-	For State Registrar	State	of Mary	land / Depa <i>Cei</i>	artment of H rtificate of	lealth and <i>Death</i>	d Mental Hy	/giene () 4	35527
			1. Decedent's Name (First, Middl	e, Last)					2. Date of D			3. Time of Death
	Physicia		Jacqueline Ru	th Porte	r				Octobe	r 20, 20	Year 004	7:50 P M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and	n <i>umber</i>)		4b. City, Town, o	or Location of De		-	ty of Death	1
	LAGITIE	C1	2708 Urbana D	rivo			Silver	Spring		Mon	ntgom	20201
	Éumanal		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 F	Irs. 8. Date of B	irth	9. Birth	nplece (State or Foreign
	Funeral Director		213-56-0672	1 □ M 2 🖸 F	=	54 Yrs.	Months Days	Hours M	Dec 2	irth lay, Year) L, 1949	Was	hington, DC
		-	Usual Residence of Decedent					1				
	land ow		10a. State 10b. County		10	c. City, Town or Lo	ecation					10d. Inside City Limits
	Man-fish	ţō	Maryland Mont	gomery		Rockvil	1e					1⊠Yes 2□No
	the 28a	Director	10e. Street and Number	90027		1100111	10f. Zip Code			10g. Citizen of	What Co	untry?
	With Sa or		956 Paulsboro	Drive			20850	1		US	λ	
	eath	era	11. Marital Status		ecedent Ever	in U.S. 13.	1		(Specify Yes or N			ncan Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amounts: If item 27 is marked other than "natural", or items 23a or 28a-f show any july to prine traumatic svent, its Macfal Expriner must be notified at anone.	by Funeral	1 Never Married 2 Mar 3 Widowed 4 ADivorced	ried Armed	Forces? es 2.⊠No		If Yes, specify Cub 1 ☐ Yes 2 🔼 No	an, Mexican, Pu	uèrto Rican, etc.)		ack, White ify: Wh	e, etc. nite
Ş	hou	ed	15. Deceder	nt's Education		16a. Dece	dent's Usual Occur	pation		16b, Kind of 8	Business/I	Industry
15	in 72 n" r	Completed	(Specify only highe			(Give	kind of work done DO NOT use retire	during most of a d)	working			
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5	filed Hygi ther		17. Father's Name (First, Middle,	Last)			Jgram IIDE		Name (First, Middle			, verimiene
an	d be ental ced c	o Be	Preston Lee B	rvant.				Rita	M. Brid	αe		
<u>-</u>	shoul od Me mari	ဥ	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street		Rural Route Num	3	n, State, Z	ip Code)
≅	d 2 s th ar t7 ls trau	'ni	Nicholas L. Po	rtor/ So	n	956	Paul chor	o Drivo	, Rockvi	110 MD	2005	.0
Ġ,	1 an Heal em 3	1	20a. Method of Disposition	rcer/ 50		Ob. Place of Dispo	sition (Name of		Date	20c Location		
و	Ser in a		1 ☑ Burial 2 ☐ Cremation		om State		matory or other pla Heaven	ce) Oct	tober 25,	-	-3970	vec is two
altimore,	rtmer rtant		`4 □Donation 5 □Other (S)	Ceme	tery 2. Name and Addre	an of English	2004	Silver	Sprin	ng, Maryland
Ba	Depa Impo any i		21. Signature of Funeral Service	- Co	2	Fı	rancis J.	Collin	s Funera			g, MD 20901
			23a. Part1. Enter the disease, o shock, otheart failure. List Immediate Cause (Final	r complications the tonly one cause of	at caused the on each line.	death. Do not ent	ter the mode of dyi	ng, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)			ic kectal ensequence of):	L Cancer					18 Months
	LAMITINE	e.	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a co	onsequence of):						
	cuted	Examiner	that initiated events	S c							-1	
, 0,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due	to (or as a co	onsequence of):						
8760,	ate b	dical		d								
9	ing p	Ψ:	IF FEMALE:	00 11								
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	1 □Liv	outcome of p ve birth 2	Fetal death 3	Ectopic pregnanc	у			ate of deli Ionth	very Day Year
0.	that the death certific ed by the attending p detached for use as	Physician/M	1 ☐ Yes 2 🕱 No 9 ☐ Unknown		regnant at time nknown	e of death 5L	Other (specify) _					
Q _	that the		Part II. Other significent conditi	ions contributing t	to death but no	ot resulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use cor	ntribute to	the cause of death?
Vital Records,	The law requires ite has been signi age 2 should be	ted by							_ 1	Yes 2√2 No	3 □ Pro	obably 4 Unknown
ec	e law has b	Completed							24a. Wa	s an 24b. opsy formed?	. Were aut prior to c death?	topsy findings available completion of cause of
=	(0 14	Ö							1 ☐ Yes		1 🗆 Yes	2 No
/its	ician: T certificat rector, pa	Be	25. Was case referred to medica examiner?				OH		Death (Check only			
of	w 17	2	1 ☐ Yes 2 🛣 No			2 ER/Outpatie		4 Nursin	g Home 5 Res	sidence 6 🖾 Ot	ther (Spec	Mother's
nc	offer offer one	ertification;	27. Manner of Death 1 XNatural 5 ☐ Pendi		ate of Injury Jonth, Day Ye	aar) 28b. Time o	Wo	ryat rk?]Yes 2 □ No	28d. Describe	how injury occu	irred	Residence
Sic	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could	not be	lace of Injury	- At home, farm, st		,	28f. Location	(Street and Nurr	nber or Ru	ral Route Number,
Division	after after Dire	erti	4 Homicide determ	mined 208. Fi	uilding, etc. (5	Specify)	, , ,		City or Te	own, State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C		I Exeminer: On th		amination and/or in			ace, and due to the courred at the time			
	ro th within ro th	Me	29b. Signature and title of certific	er		/	29c. Licen:	se number		29d. Date sign	ed (Month	n, Day, Year)
			Mar	100	SU	John	D4:	3083		Octob	er 2]	L, 2004
	12		30. Name and address of person George A. Sot	who completed o				Orive. ±	#300, Roc	kville	MD :	20850
	. Sta		31. Date filed (Month, Day, Year	r) 3:	2. Registrar's	Signature >	Spark					
	Regist	rar	OCT 25	ZUU4	14 ener	~	page oracle.	au-				

State of Maryland / Department of Health and Mental Hygiere [] [] [4 35528 For State Registral Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 21 Day 2004 ar Occupith. **Physician** 8:25AM Henry Edward Potts, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 13610 Padgett Crt. Charles Charlotte Hall
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min Months **₩** 2 □ F Yrs. Director 216-28-7860 70 Dec. 10, 1933 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show s 23a or 28a-f show 1 ¥Yes 2 □ No Director Maryland Charles Charlotte Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13610 Padgett Court 20622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status the Medical Examinent 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: δ White 3 Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hyglene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Inspector Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Edward Potts, Sr. Helen Louise Lord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie G. Potts/wife 13610 Padgett Court, Charlotee Hall, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dentsville Methodist
cemetery 20a. Method of Disposition 20c. Location - City or Town, State Oct. 23, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2004 La Plata, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Funeral Service Licensee Your 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) onces Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (lease of injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medical esn. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 2 No 1 Yes 1 Yes Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 22 No 3 DOA t) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospitel or Attending if within 24 hours after death.
To the Funerel Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 St. Patrick's Dr., Suite 404, Waldorf, MD 20603 Nalin Mathur, M.D. 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

2004

			1- State C	f Maryland /			of Health of Death		lental Hy	giene Reg. No.	711111	35529
	Physicia	an	Decedent's Name (First, Middle, Last)						2. Date of D			3. Time of Death
	/Medic	al	Thomas Milton			4h Ch. T.		- (D 1 h	OCTOR		2 2004	905 PM
	Examin	er	4a. Facility Name (If not institution, give street and nu Residence: 2309 Old Mou		d	40. CRy, 10	wn, or Location Joppa	of Death		40.	County of Deal	n ford
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last I		If Under 1 Y	ear If Under	24 Hrs.	8. Date of Bi	rth	Q Bid	hplace (State or Foreign
	Director		212-34-5804 ¹₽ ^{M 2□F}	67	Yrs.	Months	ays Hours	IVIII.	May 25	, 19:	37 M	aryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation						10d. Inside City Limits
	Mary	to	Maryland Harford				Joppa					1 ☐ Yes 21 No
	th the	Director	10e. Street and Number			10f. Zip Co				10g. Citiz	zen of What Co	•
	ath wi	ral	2309 Old Mountain Road				21085				U.S	
	ours after death with the Maryla rel', or Items 23e or 28a-f ehov Exertinet: ust be raffflad at	Funeral	11. Marital Status 12. Was Dec Armed Fo		13. W	as Deceden Yes, specify	of Hispanic Or Cuban, Mexica	rigin? (Spen, Puerto	ecify Yes or N Rican, etc.)	0-	 Race - Ame Black, Whit 	
	urs af	by	3 ☐ Widowed 4 ☐ Divorced	ve	1	☐Yes 2D2	No Specify	:			Specify:	White
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4	be filed within 72 hc tal Hygiene. Id other than "netu event, the Medical	du	Elementary/Secondary (0-12) College (Twelve Years	1-4or 5+)		NOT use i	_{etired)} Operato	r			te Star	Meon Maryland
2	filed Hygie other ent,		17. Father's Name (First, Middle, Last)			WIICI			(First, Middle	-		Haryrand
3	lid be dental rked o	To Be	Albert Pear	ce					Haze1	Ruby	Hutcher	ns
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or Items 23e or 28a-f ehow is marked other than "neturel", or Items 23e or 28a-f ehow reumatic event, Ite Medical Extending to ust be neithfield at	- N	19a. Informant's Name/Relationship (Type, Print)	1.1	9b. Mailing	Address (S	reet and Numb				Town, State, 2	
2	permit. Pages 1 and 2 should b Department of Health and Ment Importent: If item 27 is marked any injury or other treumatic e once.		Susan H. Elliott (Sist		75 Pr	incip:	lo Road		t Depo			nd 21904
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	iit. P. crtme crtent injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	K.A.		Name and A	ddress of Facil		26/04	west	Chester,	Pennsylvania
ב	permit. Departi Import any inj once.		Thomas. h. troosex	200. Sr	Le	e A.	Patters	on &	Son Fu	nera:	1 Home,	P.A.
			23a. Part1. Enter the disease, or complications that a shock, or heart failure. List only one cause on a	aused the death. Deach line.	o not ente	the mode o	dying, such as	cardiac	or respiratory a	rrest,	.,30	Approximate Interval Between
ı	Physician		disease or condition	yocaroli	al	infa	as the	N			4	Onset and Death
	/Medical Examiner		resulting in death) Due to	or as a consequenc	ce of):	+1	0 0	2y)	disea	
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í	death e atter d for u	Physician/M	1 Ves 2 No	oirth 2 🗆 Fetal dea nant at time of death		ctopic pregr Other (speci				-	Month	Day Year
)	at the by the	hys	9 ☐ Unknown									
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	he law has l	du	- Olmmenodeflere	ncy A	epico	egge			24a. Was auto perfe		prior to death?	topsy findings available completion of cause of
5	sicien: Th certificate rector, pag	O	25. Was case referred to medical				26 Plac	e of Death	1 Yes	2 No	1 ☐ Yes	2 No
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=	ding Phys h. After this funeral di		27. Manner of Death 1 ▼Natural 5 □ Pending (Mon	of Injury 28b	o. Time of Injury		Injury at Work?		28d. Describe	how injury	occurred	
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2	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours atter death. within 24 hours atter death. to the Funeriel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ertif	determined 200, Flatte	of Injury - At home, ing, etc. (Specify)	rarm, stree	et, ractory, or	rice		City or To	wn, State)	I Number of Hu	ral Route Number,
	To the Hospitel or within 24 hours after to the Funerel Dir completely filled in	alc	29a. Certifier 1 Certifying Physician: To the	best of my knowled	ige, death	occurred at t	ne time, date ar	nd place, a	and due to the	cause(s)	and manner as	stated.
	the Ho	ledical	(Check only one) 2 Medical Examiner: On the band man	asis of examination a ner stated.	and/or inve			ath occurr	ed at the time,			
	vit To Con	M	29b. Signature and title of certifier	4:			censø number				signed (Month	
'			30. Name and address of person who completed cause	JIME	a) (Tunn D	Dee	14206			COR	101 23	200 f
	5		BERMAN J. YUKIA. M.	1. 1) ME 7	OB	HOLAR	IRN A	VE	RALTO	Md	21222	
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. F	se of death (Item 23a	back	1			4. 14.			
		200	T T T T T T T T T T T T T T T T T T T	- 6E ES	THE PERSON NAMED IN							

State Registrar 31. Date filed (Month, Day, Year) 32. 866 NOV 0 9 2004

rson who comple

30. Name and address

32. Begistrar's Signature 4 April 111 Penn Street, Baltimore, Maryland 21201

teath (Item 23a) (Type, Print)

W

O.C.M.E.

November 02, 2004

State of Maryland / Department of Health and Mental Hygiene 2004 35532 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Day 3, 2. Date of Death 3. Time of Death **Physician** Month Kosen berger 4b. City Town, or Location of Death Bernard rank November 2004 1:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Deeth Glade Valley Nursing&Rehabilitation Walkersville Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 916 Birthplace (State or Foreign Country)
 Ohio 286/18/1209 Yrs. Director 88 January 19, Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location other than "natural", or Items 23a or 28a-f show vent. The Medical Examiner is ust be notified at 10d. Inside City Limits MD Frederick Directo 1 ☐ Yes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 2100 Whittier Dr. Funeral 21702 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 +4 Sales Engineer Plastics 27 is marked othe traumatic svent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jesse Clarence Rosenberger ည Katherine Agatha Treier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permii. Pages 1 and 2 Department of Health a Importent: If itsm 27 is any injury or other trai 9003. 2644 Rohrersville Rd. Rohrersville, MD 21779 Ellen R. Miller (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Nov. 4, 2004 Smithsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home Μοιζην 12525 Bradbury Ave. Smithsburg, Maryland 21783)qvis 23a ran1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Incumpnia Day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to for as a consequence off be executed burial-tran and Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physiclan/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has of Vital 1□ Yes 2√ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) P 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 Pending death. 2 Accident investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51643 Shah HIOCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rederick 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiens not.

			7 = State Registrar		$C\epsilon$	ertificate of	Death	Re	g. No. UU4	33334
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Physician /Medical			Richard Gary Rayman					Month OCTOBER	Day Year 200	4 12:58P. M
/Medical Examiner			4a. Facility Name (If not institution, given	4b. City, Town, or Location of Death			4c. County of Death			
			702 MOORING ROAD			OCEAN	CITY		WORCESTE	ER
	Funeral		Social Security Number 6. 9		e (In yrs. last birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	(Year) 9. B	irthplace (State or Foreign
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	pu 💃		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ncation		oury 20	1204	10d. Inside City Limits
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iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It Item 27 is marked other than "natural", or Itema 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director			1 Never Married 2 Married 1 1 Yes 2 No If Yes, Give 1 Yes Var or Dates:				Specify:		Specify: Wh	nite
21215-0036	2 hot		15. Decedent's E		16a. Dec	edent's Usual Occu	pation	. 1	6b. Kind of Busines	
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<u>ā</u>	should bind Ments marked	To	James Rayman				Evelyn F	Ridenour		
Maryland	and is ma		19a. Informant's Name/Relationship				t and Number or Rur			
≥ `	and ealth n 27		Nancy Rayman (Wi	te)					Frederick	, MD 20678
ore	of H		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ace) 10/24/04	Date 20	Oc. Location - City of	or Town, State
Ē	Pag ment tant:		' 4 ☐ Donation 5 ☐ Other (Speci	(y)	_	itan Cre	-			, Virginia
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Lice	nsee						PA, 4405
_	00 F 4 0	al d	10/1000	10 CL			sl. Rd., F			7
Г			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li	the death. Do not er ne.	nter the mode of dy	ing, such as cardiac	or respiratory arres	St,	Approximate Interval Between
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687	ificate g phy as the	/Medical		0.						
Вох		-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of d	elivery
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rd	w require been sig should b							1 ☐ Yes	2 ,5 €No 3□F	Probably 4 DUnknown
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m		mo:						✓ performe	ad? death? ⊒No 1 Aye	s 2 No
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	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	29b. Signature and tiple of certifier			29c. Licen	se number	290	d. Date signed (Mor	nth, Day, Year)
	- 5 - 0		1	1 //		0.0	.M.E.	\sim	TOBER 22	2004
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type		•11•10•		TODEN ZZ,	,2004
	12		JACK M. T	Tu, m.D	(==u) (1)pa		Street I	3a1⊥≛-		-3 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	s Signature	77 A	Street, I	~~T£JWOI€	, Maryla	na 21201
	Registr		OC T 2	5 2004 ▶ ,	logical St	Donass	•			

10d. Inside City Limits

1 ☐ Yes → No

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		3	Tim	a of	Des	ath

Physician /Medical Examiner

GRACE ROBISON

Year 2040™

B07

WHITE

Approximate Interval Between Onset and Death

Year

Funeral

Director 28a-f show 0 or Items 23a "naturel",

other treumatic event, the Medical Examiner must be nutified at

12 should be filed within 72 h and Mental Hygiene." 7 is marked other then "n Department of Health a Importent: If item 27 is eny injury or other tre gace.

Physician /Medical Examiner

The law requires that the death certificate be executed burial-transit attending physician for use as the buria Box 68760 P.0. the à Records, certificate Division of Vital To the Hospitel or Attending Physicien: this After the death. Director: in by

Be

Certification:

cal

Director Funeral þ Completed Be Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗆 Unknown à Completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL STOV If Under 24 Hrs. MEMORIAL 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days 1 □ M 2 X F Min. WEST VIRGINIA 93 Yrs. 358-03-5028 Usual Residence of Decedent 10h County 10a State 10c. City, Town or Location CAROLINE PRESTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21182 MARSH CREEK RD., LOT E-30 21655 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 TELLER BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FRANKLIN H. CHIPPS METTA ALICE DUNHAM 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNA MEEKINS/GRANDDAUGHTER 607-C GOLDSBORO ST., SALISBURY, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) CALVARY CEMETERY | 10-16-2004 | MORGANTOWN, WVA FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA MERCERO. NHOL 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9□ Unknown

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown 24a. Was an

autopsy performed? 2 300 1 Yes 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Statural 2 Accident

3 Suicide

29a. Certifier

4 | Homicide

(Check only

5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier

29c. License number 000531 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219 S. WASHINGTON ST EASTON, MD 21601 DENNIS M. DESHIELDS M.D.

Registra

24 hours a

within 2

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar () L 35536 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SALLIE LEE RICKER OCTOBER 2004 8:20PM M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL MANOR EASTON TALBOT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Oay, NOV . 25 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M 20F Yrs. TEXAS Director 440-48-6053 102 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at XXYes 2 □ No Director EASTON MD TALBOT 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? 5 or Items 23a 501 DUTCHMANS LANE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ ∑No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 汉 No WHITE þ 3 XWidowed 4 □ Divorced Specify: "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any vioury or other traumatic event, the Med app. office. College (1-4or 5+) Elementary/Secondary (0-12) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) GEORGE ANDRE ST.LOUIS SALLIE ELIZABETH CHEEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLIE RICKER SNOW/DAUGHTER 33506 TUCKAHOE RIVER ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION CTR. 10-11-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON MD 21601 JOHN R. MERCE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a curisequence of Examine death certificate be executed burial-transit and Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy for t 2 Fetal death Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 Probably 4 Dunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes ⊶2 ☐ No 2[] No 1 Yas Physician: Be 25. Was case referred of medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 1 🗌 Yes ٩ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA this of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Patter death,
Director: After t Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dir 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANCHEZ, M.D.508 IDLEWILD AVE EASTON, MD 21601 ROBERT B. 31. Date filed (Month, Day, Year) Registrar Signature 2 Registrar

State of Maryland / Department of Health and Mental Hygiene 35537 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** OCTOBER 24, LUEVEAIN ROWE 2004 8:55A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** SOTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGES 8. Date of Birth (Month, Day, Year)
SEPT. 23, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M XXF Months Days Hours Min. Yrs 578 12 9733 95 1909 SOUTH CAROLINA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at XX Yes 2 No Directo MARYLAND PRINCE GEORGES SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2203 PORTER AVENUE 20746 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify BLACK þ XX Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF (ROWE'S ESSO) SERVICE STATION OWNER 11TH17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H lent: If item 27 ie marked ott NANNIE ROSS GEORGE AUSTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a : if item 27 is JERRI C. McLEAN / DAUGHTER 2203 PORTER AVE. SUITLAND, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of importent: If any injury or once. RESSURECTION CEMETERY 11/01/2004 CLINTON, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. lar 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALDIOVASCULAR MISERSE THOROSCLEROTIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown ate has been signed page 2 should be det Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, HEMRIT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 Proutpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 Tes 2 No investigation death 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide 29a. Certifier t 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 9 PHYSICIAN D0053782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUTE # 101, FT. WASHINGTON VEXCHEST 11701 LIVINGSTON RD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene) 35538 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:14 M N. Kobinsor October 21 Sala 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Drive BelTsville Acres George 5 /easonit Prince If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 56 9590 Director Mar. 10, 1941 Wash Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location or 28a-f show 10d. Inside City Limits 1XYes 2 □ No Prince Director MD Georges ph 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 783 Acres 20 USA easant Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No W Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" is marked other than "nature eumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabl years none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edna K. Griffin Kiser + Salah Robinson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other treu once. 10811 Pleasant Griffin Adelphi MD 20783 Κ. Mother Acres Dr. nc-20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory Burial 2 Cremation 3 Removal from State sate of Heaven 4 □ Donation 5 □ Other (Specify) 10/27/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility T. Rhines Joh lucer 23a. P.n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosylerotic Hypertensine Heart Disease Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, have, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consecuence off burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No the Hospital or Attending Physician: Be director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1- Yes 2 □ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after deal 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 150055927 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVADOR 3001 Hospital 31. Date filed (Month, Day, Year) 3 Registrar's Signature State 2 6 2004 Registrar

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J		1 State	State of Ma	aryland / Dep	aπment of F ertificate of		, ,	0001	25520
		Registrar 1. Decedent's Name (First, Middle, Last)		06	Timeate or	Dealii	2. Date of Dea	Reg. N 6. [] [] [.	3. Time of Death
Physic		Jermaine	A. Ri	ley			Month October		ear 4 12:52 A. M
/Med Exam		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, o	or Location of Death		4c. County of	
		4745 Marlboro Pike				L Heights		Prince (George's
Funera		5. Social Security Number 6. Sex 18–15–7151	7. Age M 2□F	e (In yrs. last birthday, 27 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day August 10	Year) 9	Birthplace (State or Foreign Country)
Directo	4	Usual Residence of Decedent					August 10), 1902	Washington, D.C.
nyland how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
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5-0036 72 hours after death with the Maryland neture!; or items 23e or 28e-f show also I have ment to mail to a mail		10e. Street and Number 4108 Um Street			10f. Zip Code	20743		10g. Citizen of Wha	-
leath ns 23	Funeral		2. Was Decedent 8	Ever in U.S. 13.	Was Decedent of H		pecify Yes or No-	U.S.	American Indian,
or iter		1 Never Married 2 Married	1 Yes 2 X	No	Was Decedent of H		Rican, etc.)		White, etc.
215-0036 thin 72 hours af e. e. "neturel", or	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify:	BLACK
72 hours	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retire	ation during most of work	king	16b. Kind of Busin	ess/industry
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arylan should be nd Mental marked c	ToB	Charles Rile	. Y				Phyllis S	pencer	
and and seminary		19a. Informant's Name/Relationship (Typ			ing Address (Street				
C = M L		Barbara J. Staton (Gran	LA'Du'er)	20b. Place of Disp	Um Street		Lgnus, Mar		
Store		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, cre	ematory or other plane emorial Parl	ce)		20c. Location · Cit	er, Maryland
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or othe		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Sinature of Funeral Service License	θ		2. Name and Addre	ss of Facility R		FRAL HME.	N.
D Ped m		ant C. h	dece		4339 H.NT PI				
		23a. a.1. Enter the disease, or complications, or heart failure. List only one	ations that caused a cause on each lir	the death. Do not en	iter the mode of dyin	ng, such as cardiac	or respiratory are	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	/	nottep	1	inelist	Nou	ods	Onset and Death
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/60, e be executed rsician and e burial-transit		resulting in death) Last	Due to (or as	a consequence of);					
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BOX 687 death certificate e attending physical for use as the learning	Physician/Medi	IF FEMALE:	3c. If yes, outcome	of pregnancy				I	
BOX leath cert attendin	clan	in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy	/		23d. Date of Month	delivery Day Year
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ecords, law requires t as been signe							1 🗆 Y	es all No 3[☐ Probably 4 ☐Unknown
e 2 st	ompleted						24a. Was a autops	sy prioi	re autopsy findings available
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ystcier ystcier is certif	o Be	25. Was case referred to medical examiner? 1 X Yes 2 No	ospital:	nt 2 ER/Outpatie	et all pos Ott	26. Place of Deat			Δ± scene
O E FE	1	27. Manner of Death	28a. Date of Injur (Morth, Day	ry 28b. Time o				ow injury occurred	(Specify) At scene
DIVISION of or Attending (after death. Director: After din by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	10/17/	oy ooy		Yes 2/No	Sug	lest &	Lot
DIVISIC of or Attendant after death Director:	ertification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, st c. (Specify)	reet, factory, office	•	28f. Location (Si City or Town		or Rural Route Number,
Hospitel or thours after Funerel Dir tely filled in	0	29a. Certifier 1 ☐ Certifying Physi	ician. To the boot	STIL	201		4245	Mach	on file
UNISION OF Attention of Attention 24 hours after death of Funerel Director: letely filled in by the	edical	(Check only one) 2 Medical Examin	er: On the basis of and manner sta	of my knowledge, deal examination and/or in tted.	nvestigation, in my o	me, date and place, ppinion, death occur	and due to the c red at the time, d	ause(s) and manne late and place, and	due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (N	fonth, Day, Year)
		1 Closed	us)		000	ME	(October 1	.7, 2004
R (5)				eath (Item 23a) (Type					
	tate	31. Date filed (Month, Day, Year)	Registra	ar's Signature	11	1 Penn St	reet, B	altimore,	Maryland 2120
Regis		OCT 2 6 2004	Ban	B A					

			For State Registrar	Sta	ite of M	laryland	d / Depa <i>Cei</i>	irtment (<i>tificate</i>	of Health <i>of Deatl</i>	and M <i>h</i>	lental Hy	giene	004	35540
	Physicia		1. Decedent's Neme (First, Mich.) ABRAH	Idle, Last)	1	RAN	10F.	SK	1		2. Date of De Month OCTOB	Oay_	4 200 Veer	3. Time of Death 5:15 A M
	/Medic Examin		4e. Fecility Name (If not institut Hebrew Home o	ion, give street a f Great	and number er Was	hingt	on	4b. City, To Rocky	wn, or Location 7 i 11e	n of Death			ounty of Dee ontgom	
	Funeral Director		5. Social Security Number 577-40-3662	6. Sex 1 🗓 M 2		ge (In yrs. I	ast birthday) Yrs.	If Under 1 \ Months C	Year If Unde Days Hours	er 24 Hrs. Min.	8. Date of Bird (Month, Da Nov. 4,	y, Year)	9. Bir Co New	thplace (State or Foreign ountry) York
	ryland how		Usuel Residence of Decedent 10a. State 10b. Cour	•		10c. City	, Town or Lo							10d. Inside City Limits 1 Yes 2 XNo
	the Ma 28e-f	Director	Maryland Mon	tgomery			SIIV	er Spri				10g. Citize	n of What Co	
	h with	D	8720 Leonard	Drive					20910)		Unite	d Sta	tes
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "naturel", or Iteme 23a or 28e-f show raumatic event, the Micral Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ M 3 □ Widowed 4 □ Divorce	larried 1 [as Deceden med Forces Yes 2 5 Yes, Give ear or Dates	? (No	1	Was Deceder f Yes, specify			ecify Yes or No Rican, etc.)		. Race - Ame Black, Whi pecify: W	
Maryland 21215-0036	thin 72 hour e. en "neturel Modical E.	Completed t		lent's Education hest grade com			16a. Dece (Give life.	dent's Usual (kind of work of DO NOT use	Occupation done during ma retired)	ost of worki	ing	16b. Kind	of Business	/Industry
2	led wi	Co	17. Father's Name (First, Midd	lo (act)	5+		Stat	istic		ther's Name	(First, Middle			vernment
and	ild be fi lental H kad oti ic ever	o Be	Isadore		у						Reznic			
lary	permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked c any injury or other traumatic every once.		19a. Informant's Name/Relation				1				Burton			
ē,	t and Health tem 27		20a. Method of Disposition				lace of Dispo	sition (Name natory or othe	of		Date			Town, State
altimore,	Pages nent of ant: If I		1 1 Burial 2 ☐ Crematic 1 1 Donation 5 ☐ Other		al from State	0	-		netery	10/2	6/04	Adel	phi, l	MD
Balt	Departr Mports Imports Iny inji		21. Signature of Funeral Servi			_	To	orchins		rew F	uneral			
			23a. Pert Enter the disease shock, or heart failure. I	, or complication	s that cause	ed the death	n. Do not en	of Cari	roll St of dying, such	as cardiac o	Washi of respiratory a	i <mark>ng ton</mark> rrest,	, DC	20012 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	C	OPI	2							Onset and Death
d	/Medical Examiner		resulting in death)		Due to (or a	LI I	uence of):							
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. —	Dua to (or a	e a consequ	uenca of):							
	and and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.	Due to (or a	is a conseq	uence of):							
8760,	licate be executed physician and is the burial-transit	dical E		d					1100					
.O. Box 68	The law requires that the death certifics are has been signed by the attending pt page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 4	yes, outcom □Live birth □Pregnant □Unknown	2 ☐ Feta at time of d	I death 3	Ectopic preg				23	d. Date of de Month	elivery Day Year
s, P	ires that th signed by d be detacl		Part II. Other significant cond	ditions contribut	ting to death	but not res	ulting in the u	nderlying cau	ise given in Pa	irt I.		lobacco use		to the cause of death?
Vital Record	ysician: The law requir is certificate has been si director, page 2 should	Completed									24a. Was auto perfo			
ta		0	25. Was case referred to med	lical					26. Pla	ace of Deat	h (Check only		1016	5 220,110
of V	Physician: this certific ral director,	To B	examiner?	Hospit	1 🗀 Inpa		ER/Outpatie				me 5 Resi			ecify)
on (Jing After fune	tlon:	27. Manner of Death 1 Natural 5 Per 2 Accident		a. Date of Ir (Month, E	Day Year)	28b. Time o Injury	M 280	c. Injury at Work? 1 🗆 Yes 2		28d. Describe	now injury o	ccurred	
Division		Certification:	3 Suicide 6 □ Co	uld not be ermined 28	e. Place of I building,	Injury - At he etc. (Specif	ome, farm, st	reet, factory,	office			Street and i wn, State)	Vumber or R	Rural Route Number,
	Hospitel or the hours afte Funerel Dir tely filled in the tell filled in the tell filled	edicai ((Check only 2 Medi	fying Physician cal Examiner: (On the basis	of examina								as stated. e to the cause(s)
	ro the vithin 2 Fo the complet	Med	29b. Signature and title of ser		and manner	stated.	110	29c.	License numbe				-	oth, Day, Year)
)	25		> Banka	va de	close	nes	M.U.	1	7354	_		UCTO:	382 :	24,2004
			30. Name and address of per	son who comple	ted cause o VZU	Ideath (Iter	n 23a) (Type	Print A	WYE RI	OHD,	ROCKI	ILLE	HD	20852
4	St Regist	ate rar	31. Date filed (Month, Day, Y	Bar) 5 2004	32. Redi	strar's Signa	ature &	Spa	eles				,	

			For State	State of Maryland	d / Depa	artment of H	lealth and M	•		2551.1
			Registrar		Cei	rtificate of	Death		9. 140.	35541
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al .	Michael Dennis 4a. Facility Name (If not institution, give			4h City Town o	or Location of Death	10	23 200 4 4c. County of Death	
	Examin	er							Cecil	
	Funeral		Union Hospita: 5. Social Security Number 6. Ser		ast birthday)	Elkto If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		138-24-8599 15 Usuel Residence of Decedent	^M 2□F 70	Yrs.	Months Days	Hours Min.	June 2	5, 1934	NJ
	yland		10a. State 10b. County	10c. City	Town or Lo	cation				10d. Inside City Limits
	a-f s	ctor	MD Cecil	Che	sape	ake Cit	у			1 ☐ Yes 2 ☐ No
	within 72 hours after death with the Maryland ene. than "neturel", or liems 23a or 28a-f show is Madical Examinar, and be netitived at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	ath w		53 Pleasure Sh	nores Circle		219			U.S.A.	
	er de	Funeral	11. Maria States	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of h If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ X No	Specify:		Specify: Wh	ite
Ş	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation	. 1	6b. Kind of Business/I	
215	nin 72 in "n	plet	(Specify only highest grad	e completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of work d)	ing		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "neturel", or litems 23a or 28a-f show armatic event, the Marical Exactinests and be notified at	Completed	12	4	Es	timator	,		Construc	tion
p	al Hygie I other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name		laiden Sumame)	
<u>ya</u>	2 should be fi and Mental H Is marked ot aumatic ever	2	Joseph J. Rear					n Vail		
lar	2 sho and Is mu		19a. Informant's Name/Relationship (Ty	•					City or Town, State, Z.	ip Code)
	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		Kathleen Reardo	on/Daughter	_13_1	Hatters	Court,	Hatbord	D. PA 19	040
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	temoval from State	metery, crei	matory`or other pla	ce) Octo	ber	ŕ	
ij	Pa Int:		'4 □ Donation 5 □ Other (Specify)				nc. 26,	2004	West Ches	ter, PA
Bal	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	2		2. Name and Addre Andrew	G. Gee F	ineral	HOme	
		_	23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the death	. Do not en	259noEasi	to sMajondias	Lesprator Falre	ston, MD	AZoloxinZial
			shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.		,	- gi			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	anao of):					
	Examiner			Aspirator		20.0				
		er	Sequentially list conditions, if any, leading to immediate	Due to for as a consequ		Will.				
P	uted d ansit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Metastatic	Ren	J Cell	Corner			
Ó	te be executed ysician and e burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	ence of):		717077			
3760,	ate be executed hysician and he burial-transit	ical		d						
89	The law requires that the death certificat ite has been signed by the attending phy agge 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE:							
Box	ath ce ttendi	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnanc	у		23d. Date of deliment	/ery Day Year
	ie dea the al	/slcl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	ath 5	Other (specify)				
P.0	hat the deby detacl	Ph)	Part II. Other significant conditions co	ntributing to death but not resu	lting in the u	nderlying cause or	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds,	ires that signed b	d by	Advenay Insuff	-	, , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 🗀 Ye	s 2XNo 3 Pro	bably 4 🗆 Unknown
Š	w requir been si should	ete	243					24a. Was an	24h Were aut	opsy findings available
Records,	ne lav has ge 2	mp						autopsy perform	prior to c death?	ompletion of cause of
a		e Co	25. Was case referred to medical				26 Place of Boot	1 Yes 2	No 1 □ Yes	2 L No
Division of Vital	Physicien: this certificated director,	To Be	examiner?	Hospital: 1 Malnpatient 2 □	ER/Outpatie	nt 3 DOA Ot	hor		nce 6 ⊡Other <i>(Spec</i>	ifv)
of	문 부 Te	H:	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju		28d. Describe ho		,7
ion	Attending or death.	atlo	1 Natural 5 Pending 2 Accident investigation	(World, Day 1 ear)	Injury		Yes 2 No			
Vis	Atte er deg ecto by th	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru. State)	ral Route Number,
	tal or rs afte el Dir ed in	Certification:		, , , , , , , , , , , , , , , , , , , ,						
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the i	Medical		sician: To the best of my know iner: On the basis of examinat and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Month	, Day, Year)
	- 110		> (STATE)	>		Do	056377		10/23/04	
	1		30. Name and address of person who c	ompleted cause of death (Item		Print)				
	13		Cydney T. T.	eal mD 1	11 Wa	st High	Street Sui	ine 312	Eller m	721921
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 6 200	32 Registrar's Signal	ure do	whe				

			For State Registrar	State of Maryl		artment of F			iene 004	35542
			Decedent's Name (First, Middle, L.)	ast)				2. Date of Dear	th	3. Time of Death
	Physicia		Virginia	Bessie S	Sirbaugh			October	Day Yes	
	/Medio Examin		4a. Facility Name (If not institution, g		J., 2 d. d. g	4b. City, Town, o	r Location of Dea		4c. County of D	
	LAGITIII		M	1		Cumber1	and		Allega	anv
	Funeral		Memorial Hospita 5. Social Security Number 6		vrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi	s. 8. Date of Birth	0	Birthplace (State or Foreign
	Director		215-18-8661	^{1□ M 2} ♥ 81	Yrs.	Worth's Days	Hours IVIII	Feb 27,	1923 N	MD (
	pu M	}	Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or Lo	cation				10d. Inside City Limits
	shot	5	MD Allega		•	erland				1 ☐ Yes 2 ☐ No
	he M	ect	10e. Street and Number			10f. Zip Code			0g. Citizen of What	
	a or	ā	14 E. Elder St			· ·	21502		USA	Country.
	eath	Funeral Director	11, Marital Status	12. Was Decedent Ever i	in U.S. 13.			(Specify Yes or No-		merican Indian,
	fter d r Itan Ingr	F	1 Never Married 2 Married	Armed Forces?				(Specify Yes or No- erto Rican, etc.)	Black, W	
ဗ္ဗ	urs a		3 XWidowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1□Yes Z∑No	Specify:		Specify: W	hite
Ò	72 hours after death with the Maryland netural', or ltams 23a or 28e-f show dical Evanings must be rediffed at	Completed by	15. Decedent's (Specify only highest of		16a. Dece	dent's Usual Occup	ation	vorking	16b. Kind of Busine	
7	within 7 ene. than r	npie	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired	d)			
7	ed wi	S	12		Homer	naker			Own Home)
and	buld be fill Mentat H arked oth atic even	Be	17. Father's Name (First, Middle, La George H. Lloy					ame <i>(First, Middl</i> e, <i>i</i> s M. Robin	•	Buell
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "netural; or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be rediffed at ance.	은	19a. Informant's Name/Relationship	(Type, Print)			and Number or I	Rural Route Number	r, City or Town, State	e, Zip Code)
	and 2 alth a 127 l		M. Elaine Yanz	daughte	r 2998	3 Parman	Road	Dansv	ille	MI 48819
ore	of He of He litam		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		b. Place of Dispo cemetery, crei	sition (Name of matory or other place	ce)	1.5	20c. Location - City	
Ĕ	Page nent ant: Il		'4 □ Donation 5 □ Other (Spe		illcrest Me	morial Park	1	11/3/2004	Cumberla	nd MD
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Service Lic	ensee	. 22	Name and Address Scarpell	ss of Facility I Funeral I	Home, P.A.		
_	20599		//www	- 10pl	U	108 Virg	inia Aveni	ue; Cumberla		
			23a. Part 1. Enter the disease, or co shock, or leart failure. List on	mplications that caused the cally one cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition	_a _ Cardiac a	rrhythmi	a				Onsol and Dodgi
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
Н	_xaiiiiioi	<u>_</u>	Sequentially list conditions,	b. Congestive Due to (or as a con		failure				
$\overline{}$	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
1	sician and burial-transit	xar	that initiated events resulting in death) Last	c. Atheroscle Due to (or as a con						
8760,	ate be ex hysician the burial	icai								
687	ficate p phy: s the	edic		u.						
Вох	death certificate e attending phys of for use as the	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of	delivery
m	death s atte d for	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐I 4☐Pregnant at time]Ectopic pregnancy] Other (s <i>pecify)</i> _	<i>'</i>		Month	Day Year
0	that the de led by the a	hys	9 Unknown	9L Unknown						
۳,	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	s contributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
P S	quire n sig uld b	eted b			 			1 □ Y	es 2□No 31	Probably 4 Unknown
00	aw requir as been si 2 should I	siet						24a. Was a		autopsy findings available
Vital Records,	0 4 0	Comple						autops perforr 1 ☐ Yes	med? prior death 2 X No 1 ☐ Y	
tal	en: Th tificate tor, pag	a)	25. Was case referred to medical				26. Place of D	eath (Check only on		63 24110
	Phyaicien: this certific ral director,	O B	examiner? 1 ☐ Yes 2 X No	Hospital:	2 ER/Outpatier	nt 3 DOA Oth	OF:	Home 5 ☐ Reside		pecify)
J Of	g Ph er th neral	T.	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injur Wor	y at	28d. Describe ho	ow injury occurred	
Ö	Attanding Party of death. actor: After by the funer	atio	1 Natural 5 Pending investigation		a, mary		Yes 2 □ No			
Division		tific	3 ☐ Suicide 6 ☐ Could no determine			eet, factory, office		28f. Location (St City or Town		Rural Route Number,
Ö	tal or A s after at Dira	Certification;		Banang, 5.65 (5)				N		LUIS SELECTION SECTION
	To tha Hospital or within 24 hours afte To tha Funaral Discompletely filled in	edicai	(Check only 2 Medical Ex	Physician: To the best of my raminer: On the basis of exar	knowledge, deat mination and/or in	h occurred at the tir vestigation, in my o	me, date and pla pinion, death oc	ce, and due to the co	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
	To tha within 2 To tha complet	Med	one) 29b. Signature and title of certifier	and manner stated.	. (29c. Licens	e number	2	9d. Date signed (Mo	onth, Day, Year)
	⊢≱⊢ŏ		1 Swent	Malh.		D0054	/ ₁₁		stobor 20	2004
	-		30. Nam address of person wh	no completed cause of death	(Item 23a) (Tupo		-11	UC	tober 30,	4004
	5		V				luo Sto	105 Cumb	orland MAD	21502
	Sta	ate	Beverly Calkins 31. Date filed (Month, Day, Year)	M.D. 32. Registrar's S	OUU_N ignature	nemonal A	AVE SIE	105 Cumbe	THAILU IVID	Z1UUZ ,
	Regist		NOV 0 9	2004 Benev	a G	Loone	# W			
DH	IMH 17 Rev 1/2	001				1900ch				

ORIGINAL

		1	1 - For AMEND#17&18perINF11/3/04,BW,MXX0 Ce	artment of Health and Mental Hygier rtificate of Death	2004 35543
	Physicia	-46	1. Decedent's Name (First, Middle, Last) GENE CLINE	SIMON 2. Date of Death Month	22 2004 9:50A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4c. County of Death
			Doctors Community Hospital	Lanham	Prince George's
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last birthday) 1 □ M 2 ☑ F 79 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Nov. 18,	
	p >	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation	10d. Inside City Limits
	Maryla f sho				1 ☐ Yes 2 ☑ No
	r 28e-	20 -	Maryland Prince George's Hyattsv		Citizen of What Country?
	th with	a D	7006 24th Avenue	20783	USA
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	thin 72 hours after death with the Maryland e. m. "neturel; or Items 23e or 28e-f show Medical Examillar must be mailted at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specity:	Specify: White
5-0	72 ne #	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation 16b e kind of work done during most of working DO NOT use retired)	. Kind of Business/Industry
121	within ene. then.	duc	Elementary/Secondary (0-12) College (1-4or 5+)		Own Home
	be filed wilter Hygien de other the	Be Co	17. Father's Name (First, Middle, Last) J. Neff Cline	18. Mother's Name (First, Middle, Maid Sallie	
ylar		ToE	-Neil-Gilne	Sally Ann Deput	У
Maryland	2 sh and Is m			ling Address (Street and Number or Rural Route Number, Ci	
	s 1 and of Health item 27 ofther to		20a. Method of Disposition 20b. Place of Disposition		Location - City or Town, State
E	age = 50		1 Departing 5 Other (Specify) George	Washington	elphi, Maryland
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins Funeral 00 University BLvd, W, Silv	
			23a. Part 1. Inter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	P :-	Illiel Agr Dermoell
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	texte Myocardial II	greting onsorand beauti
	/Medical Examiner		Due to (or as a consequence of):	lentie Cardiovasa	yarchy onset and beath war lar Durage Years
		Jer	Sequentially list conditions, if any, leading to immediate cause. Exter I Indexiving. Due to (or as a consequence of):	Sie source (Experience)	sector block for is
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
3760,	be exercian sician s		Due to (or as a consequence of).		
687	ficate g phys	edlc	d		
Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medical	in the past 12 months? 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
P.O.	res that the de signed by the a be detached f	hys	9 Unknown		
	w requires that been signed should be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	Coolovarcular 10 Yes	co use contribute to the cause of death? 2 \(\forall No \) 3 \(\text{Probably} \) Probably 4
Records,	The law re ate has bee page 2 sho	Completed	teppestentia	DISCI C 24a. Was an autopsy performes	
Vital	ysicien: The lis certificate hadirector, page	Be Co	25. Was case referred to medical	1 ☐ Yes 2 X 26. Place of Death (Check only one)	No 1 Yes 2 No
ţ.	Physicien: this certific ral director,	To B	examiner? 1 No Hospital: 1 Inpatient 2 EP/Outpatte	ent 3 DOA Other: 4 Nursing Home 5 Residence	e 6 □Other (Specify)
n of			27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time Injury		injury occurred
Division	Attending r death.	licat	2 Accident investigation 3 Suicide 6 Could not be determined continuous. At home, farm, s	street, factory, office 28f. Location_(Stree	t and Number or Rural Route Number,
Οİ	el or A s after if Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town, S	itale)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal of the companies of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the caus investigation, in my opinion, death occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier	29c. License number 29d.	Date signed (Month, Day, Year)
	(0		1 Comments	カイダイヌ	10/25/2004
			30. Name and address of person who completed cause of death (Item 23a) (Type AS LOG 4410	74th Ave landwerth	NU MD 20784.
*	St Regist	ate trar	31. Date filed (Month, Day, Year) OCT 25 2004 32. Registrar's Signature	Sparks	

Simon, gene

		-	For State Registrar	State of Mar	•	epartmen Certificate				-		04	355	44
	Physicia	an	Decedent's Name (First, Middle, La DONNA ANN SULLI							2. Date of De	er 6,20	 ეტშ⁴	3. Time of 2355	
	/Medic Examin		4a. Facility Name (If not institution, given Memorial Ho	e street and number)			Town, or	Location o	of Death		4c. Count	y of Death		
	Funeral Director		5. Social Security Number 6. S		In yrs. last birtho	Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da MAY 4	th ay, Year) 1929	9. Birth Cou NEW	place (State on ntry) YORK	r Foreign
	iryland ihow		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town o	or Location							10d. Inside Cit X □Yes	-
	the Ma 28e-f	Director	MD TALB	OT		EASTON 10f. Zip	Code				10g. Citizen of	What Cou		2 1110
	th with	al Dir	29736 AMANDA'S	YAW		13		601				US	•	
936	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Itams 23a or 28e-f show that the Medical Examinar must be neilliad at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	Speci	ack, White,	can Indian, etc. ITE	
21215-0036	72 hours "naturel",	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	(0	ecedent's Usua Give kind of wor	rk done d	lurina mos	t of work	ing	16b. Kind of E	3usiness/Ir	ndustry	
121	within iene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ife. <i>DO NOT u</i> s ACHER/P					CORREC	TIONS	FACIL	ITY
an	should be filed within 72 ho nd Mental Hygiene. markad other than "natu metic avant, It e Modical	BeC	17. Father's Name (First, Middle, Last					18. Mothe		, ,	, Maiden Suma	me)		
111ivan Maryland	should be nd Mental markad c	ှင	LEE R. MCCLEAN 19a. Informant's Name/Relationship ((Type Print)	19h M	Aailing Address	(Street a			E KENNE	DY er, City or Towr	State 7i	n Code)	
ull,	th ar Ith ar 27 is r trau	la Control	LEE SULLIVAN/SON	-		856 CAI			IVE		MD 216		, 6646)	
Sore	Pages 1 ar nent of Hea int: If itam iry or otha		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	JRemoval from State	20b. Place of D cemetery,]		Date	20c. Location			
onna Saltim			* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice			22 Name an	d Addres	s of Facili	hu	11-2004	ELMIR			= =
Doil	permit. Departr Imports any inji		Joseph M. Os		.3.//.	200 S.	HARR	ISON	ST	EASTON	AM FUNE , MD 21	RAL H 601	IOME PA	
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	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of)	erctive	۷ ,	Pulm	9121	y di	(e= je	,	ioye=	avs
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o,	ate be executed hysician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of)):						-		
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Division of Vital Records, P.O. Box 6	To the Hospital or Attanding Physician: The law requires that the death certificat within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp						ate of deliv		'ear
rds, P	w requires that s been signed b should be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in t	he underlying c	ause give	en in Part I			obacco use cor Yes 2 🗆 No			
l Reco	The law re ate has bee page 2 sho	Completed								24a. Was auto perfo 1 🗆 Yes	psy ormed?	prior to co death?	opsy findings a empletion of ca	available ause of
Vita	Physician: The la r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			Othe			h (Check only o				
on of	ding Phys	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Y			8c. Injury Work	at (? Yes 2 ☐			dence 6 🗆 Ot how injury occu		fy)	
Division	To the Hospitel or Attanc within 24 hours after death To the Funaral Director: completely filled in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	00 00- 01	/ - At home, farm (Specify)					28f. Location (City or To	Street and Num wn, State)	ber or Rura	al Route Numi	ber,
	e Hospitel 24 hours e Funaral	edical C	29a. Certifier (Check only one) 1. Certifying P 2 Medicel Exa	hysician: To the best of miner: On the basis of ex and manner state	xamination and/	death occurred or investigation	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and m date and place	anner as s , and due t	stated. o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	go MO				number	32		29d. Date sign	ed (Month,		
			30. Name and address of person who								<u> </u>			
	_ C+-	ate	JORGE ABREGO 31. Date filed (Month, Day, Year)		S Signature			CON,	MD 2	1601				
	Regist		OCT	1 2 2004	s Signature	7. Sport	A SECOND							

			State Amend Ite	State of m 5 per FH	Marylan , G837 ,1	id / Depa L 1/26 (artment of H	lealth and N Death	/lental Hyg	jiene	004	35	545
			1. Decedent's Name (First, Midd	fle, Last)					2. Date of Dea Month	th Day	Year	3. Time o	f Death
	Physici /Medio		Barbara A	• Sumner					10	22	04	6:45	A M
	Examir		4a. Facility Name (If not institution	on, give street and num	ber)		4b. City, Town, or	Location of Death		4c. Cou	nty of Death		
			Washington Adv	entist HOsp	oital_		Takoma If Under 1 Year	Park If Under 24 Hrs.	10.5		tgomer		
	Funeral Director		5. Social Security Number 579-54-1385 Usual Residence of Decedent	6. Sex 1 □ M 2 X F	7. Age (In yrs. 64	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 07 08	, Year)	Cou	place (State ontry) Mount	
	land ow		10a. State 10b. Count	у	10c. Cit	ty, Town or Lo	ocation					10d. Inside C	ity Limits
	Many Fied	ţō	MD MOntg	omery	S	Silver	Spring					tx∑ Yes	2 □ No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?	
	th wit		735 Sligo Aven	ue #303			20910			U	SA		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "naturel", or Iteme 23a or 28e-1 show or other treumetic event, the Medical Examinar must be notified at	y Funerai	11. Marital Status 1 □ Never Married 2 ◯ Ma	12. Was Dece Armed For rried 1 Tes If Yes, Give	ces? 2. [_]MNo e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	E	Race - Americal Rack, White, scify: Bla	etc.	
5-0036	hours turet,	d by	3 Widowed 4 Divorce		tes:	16a Dana	dent's Usual Occup	ation					
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2121	within iene. r than	m o	Elementary/Secondary (0-12)	College (1-	4or 5+)	Ма	il Servic	e		U.S.	Govern	ment	
b	Hygie other	BeC	17. Father's Name (First, Middle	, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sun	name)		
<u>a</u>	should be find Mental he marked of	To B					unk	Susie	Lewis				
Maryland	and N is ma	. 3	19a. Informant's Name/Relation	iship (Type, Print)			ng Address (Street	11000 C.					
	1 and Health em 27		HUbert Sumner/	HUsband	loot r	_	Sligo Ave	. #303 Si	lver Spi				
Baltimore,	Pages 1 nent of H ent: if ite ury or oth		20a. Method of Disposition 1 □xBurial 2 □ Cremation 4 □ Donation 5 □ Other (State	cemetery, cre	osition (Name of matory or other place Memorial	10-29			er, MI		
Balt	permit. Page Department of Importent: if any injury of		21. Signature of Funeral Service	e Licensee arshal	Q	22	2. Name and Address 4217 9th						
>	Pnysician /Medical	252	23a. Part1 (Ener the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that cast only one cause on e	ich line.	th. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory arr	rest,	100	Approxima Interval Bei Onset and	tween
1	Examiner			Due to (n DSi	A						T da	15
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to fo	ur as a consec	juence of):			TM TO				t
,8760,	ate be executed hysician and the burial-transit	al Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (d	or as a c - ec	quence of):	W ije	Lemi	tų_			1 m	aidu
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O. Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Feta ant at time of c	aldeath 3	Ectopic pregnancy Other (specify)	1			Date of deliving Month	,	Year
4	uires that the signed by	d by Ph	Part II. Other significant condit	tions contributing to de	ath but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to		ontribute to t	he cause of c	
of Vital Records,	he law requir e has been si age 2 should	omplete	Periphen	P vas cule	w dis	luse			24a. Was a autops perfor	med?	b. Were auto prior to co death? 1 \(\sum \) Yes	ppsy findings impletion of c	available ause of
tal	ician: Th certificate rector, pag	a	25. Was case referred to medic	al				26. Place of Dea	1 ☐ Yes th (Check only or	No No	1 1 1 1 1 1 1 1 1	F 140	
>	Physician: this certific ral director,	To B	examiner?	Hospital:	patient 2	ER/Outpatie	nt 3 DOA Oth	05	ome 5 Resid		Other (Specia	(y)	
ion o	ding After fune	ation;	27. Manner of Death Natural 5 Pend 2 Accident inves	28a. Date of (Month tigation	f Injury h, <i>Day Year)</i>	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury oc	curred		
Division	ei or Atte s after de ii Directo ed in by th	Certification;	3 Suicide 6 Could 4 Homicide deter	d not be mined 28e. Place buildir	of Injury - At h ig, etc. <i>(Speci</i> i	ome, farm, st	reet, factory, office		28f. Location (S City or Town	treet and Nu n, State)	mber or Rura	al Route Nurr	iber,
	To the Hospitei or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)	ing Physicien: To the I Exeminer: On the ba and mann	isis of examina	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occu	and due to the c red at the time, d	ause(s) and late and plac	manner as s ce, and due to	tated. o the cause(s	s)
	To the within To the comple	Me	29b. Signature and title of certific	ier		_	29c. Licens	e number	2	29d. Date sig	ned (Month,	Day, Year)	
	7		> Kuldu	allysou,	Moop	talin	D5	238		10/	क्रिश हर	Í	
2	(8)		30. Name and address of person ROBXN D. AN	n who completed cause	of death (Iter	n 23a) (Type,	Print) WAVE	JUS TIAK	onua PAG	2K M	00 0	912	
	St Regist	ate rar	31. Date filed (Month, Day, Yea OCT 2 7		egistrar's Signa	ature	4						

			For State Registrar	State of I	Marylan		artment ortificate			and Me		giene Reg. No.		+ 35	546
	Physicia	an	Decedent's Name (First, Middle,								2. Date of De Month	ath Day	Yea	3. Time o	f Death
	/Medic	al	YASUKO SATO 4a. Facility Name (If not institution,		ar)		4b. City, To	wn. or Loc	cation of		OCTOBE		2004 County of De	11:40) AM
	Examin	er	ADVENT HOSPITAL	•	•	PITAL	GAITH						ONTGOM		
	Funeral		,	6. Sex 7. 1 ☐ M 2 ☐ F		last birthday) Yrs.	If Under 1 Months I		Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 05/09/	th y, Year)	(irthplace (State Country)	or Foreign
	Director		216-64-1591 Usual Residence of Decedent	X	89	113.				10	05/09/	1915	JA.	PAN	
	ryland how		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside C	
	Ba-f s	Director	MD MONTGO	MERY	MON	TGOMER	Y VILL				1	10- 04	zen of What (2X No
	with the		10e. Street and Number 9508 DUFFER WAY				10f. Zip C					JAPA1		Country?	
	72 hours after death with the Maryland Insturel; or Rems 23a or 28a-f show deat Exac. It set must be rediffed at	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.			anic Orig	gin? (Spec	cify Yes or No lican, etc.)	-	14. Race - An Black, Wi	nerican Indian,	
36	or Ite	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 □ Yes ※		Specify:	, i doito i	noarr, oto.,		Specify:	ASIAN	
<u>ö</u>	in 72 hours a "naturel", o		15. Decedent	Year or Date s Education	s:	16a. Dece	dent's Usual (Occupation	n			16b. Kii	nd of Busines		
215	c * 34	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4)	or 5+)	(Give	kind of work DO NOT use	done durir retired)	ing most	of working	g				
121	be filled withintal Hygiene. d other then		12 17. Father's Name (First, Middle, L	acti		HOUSE	KEEPER	10	Mothor	r'e Nama	(First, Middle		ESTIC		
Maryland 21215-0036		To Be	YOSEI KITA	.431/							BTAINA	- 44	Suriame		
ary	de E	1-	19a. Informant's Name/Relationsh	ip (Type, Print)			,				Route Numb		•		
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Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Coremation		ite (cemetery, cre	matory or othe	er place)	1					or Town, State	
計	permit. Pages Department of Importent: If ii eny injury or o	7	* 4 □ Donation 5 □ Other (Sp. 21. Signature of Fuge. I Service I	өспү)	NA	2	CREMA 2. Name and	Address of	of Facility	у	/2004	FALI	LS CHU	RCH, VA	
ñ	Dep Imp		The second	difficile	3		ATIONA 482 LE				ME ALLS C	HURCI	I, VA	22042	
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Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26	6. Place	of Death	1 ☐ Yes (Check only o	210 No		35 2 110	
of V	Physicien: this certifical director,	L _O	1 ☐ Yes 2 No	Hospital:		ER/Outpatie					e 5 Resi			pecify)	
	ding funer	tion	27. Manner of Death 1		Day Year)	28b. Time of Injury	M 280	: Injury at Work? 1 ☐ Yes	s 2 🗆 N		8d. Describe	now injury	occurred		
Division	Attending ar death. ector: After by the fune	Certification:	3 Suicide 6 Could n	ot be 28e. Place of	Injury - At h	ome, farm, st	reet, factory, o	office		21	8f. Location (Rural Route Nun	nber,
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	To the within To the comple	Me	29b. Signature and title of certifier	۸۸	00-			_icense nu				29d. Date	signed (Mo	nth, Day, Year)	
	F	1	> free	edle	elle	n	0 1	038	326	52		04	- 23	2001	1
CK	2 (10)		30. Name and address of person	who completed cause	of death (Iter	0	Print)	PMA	vr l.	121	NO 5	suit	n 22	MO 20	11600
	Sta	ate	31. Date filed (Month, Day, Year)	32 Reg	istrar's Sign	ature 240	1 ruce	١٠٠٠		170	AND C	succ	200	o vinde	~~~~
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State of Maryland / Department of Health and Mental Hygienen For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** October 16, 2004 Torrence R. Sims /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cheverly Prince George's Prince George's Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) August 7, 1953 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months **Funeral** Days Hours Min Washington, D.C. 579-74-6717 51 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ul Hygiene. . other than "netural", or Items 23a or 28a-f show vent, the Medical Examiner insist be notified at XX Yes 2 □ No District Heights Prince George's Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6425 Pennsylvania Avenue APt. #103 20747 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. □Yes 2 No hours after 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2XXNo Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 College (1-4or 5+) Elementary/Secondary (0-12) Counselor Federal Government (Retired) 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be and Mental I Pages 1 and 2 should be Eva Sims George R. Credle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6400 Seat Pleasant Drive Capital Heights, Maryland 20743 f Health a item 27 l Michelle Credle (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ∰gurial 2 ☐ Cremation 3 ☐ Removal from State 0 October 25, 2014 Washington, D.C. Glenwood Cemetery permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ture ROLLING FUNERAL HOME, INC. 21. Sign 4339 HINT PLACE, N.E. WASHINGTON, D.C. 20019 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death iate Cause (Final Cardionyorathy **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 Yes 1 Tyes 25. Was case referred to medical 26. Place of Death Check on one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ★ P/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death After 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident **Director**: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 - Homicide after within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number)aa574 s, who completed suse of death (Item 23a) (Type, Print) 30. Name and address of Old line Center # 202 waldorf Pace 1201 31. Date filed (Month, Day, Year) MO Registrar's Signature 201100 State OCT 2 6 2004

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Registrar

.11		•	For State Registrar		State of Ma	aryland /	-	irtment (<i>tificate</i>			and M	ental Hy	giene	004	3	35548
	-		Decedent's Name (#	First, Middle, Las	t)							2. Date of De. Month		Yea	T	3. Time of Death
	Physicia /Medic		Erick	Filib	erto Pe	rez Sa	anch			_		Octobe	r 20	, 2004		5:02 P ^M
	Examin	er	4a. Facility Name (If no		street and number) tist Hospi	+ -1		4b. City, To					4c. 0	County of De		
	Europel		5. Social Security Num			(In yrs. last b	irthday)	If Under 1 \	ear I	If Under:	Park 24 Hrs.	8. Date of Birl	:h	Mont		
	Funeral Director		none		X M 2□F	27	Yrs.	Months E	ays	Hours	Min.	(Month, Da 1/22/	y, Year) 1971	7 G		e (State or Foreign Cemala
	pu »		Usual Residence of De	ecedent 0b. County		10c. City, To	um or lo	ention								
	f ehov	or		•	George's	-		ville	2						100	Inside City Limits 1 Yes 2 No
	the N	rect	10e. Street and Number		dedige b	7		10f. Zip Co					10g. Citiz	en of What (Country	?
	h with	al Di	8142 1	5th Av	enue Ap	t.203		20	783	3			Gua	atema	la	
(0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury porther traumatic event, Ite Medical Examinar must be notified at once.	Funer	11. Marital Status 1 Never Married	2 ☑ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 N						gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	- 1	4. Race - An Black, Wh		
21215-0036	ours a	d by	3 Widowed 4 [□Divorced	If Yes, Give Year or Dates:		'	Yes 2		<i>Specity:</i> Guat	ema.	la		Specify: W	hit	e
5-("natu	lete	15 (Specify	5. Decedent's Ed only highest gra	ucation de <i>completed)</i>	16	a. Deced	ent's Usual C kind of work of OO NOT use i	occupation done dur	on <i>ring</i> mos	t of workir	ng	16b. Kin	d of Busines	s/Indus	stry
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<u>d</u>	illed Hygi other	e C	17. Father's Name (Fin	rst, Middle, Last)						8. Mothe	r's Name	(First, Middle,				
/lar	wild be Menta arkad	To B	Jose Pe	erez Ag	uilar							ena Sa				
Maryland	2 sho		19a. Informant's Name									Route Numbe				
e, P	1 and Health am 27 thar t		Jose Per 20a. Method of Dispos		chez/Bro			? 15th sition <i>(Name</i>		/enu		-				
Baltimore,	Pages ment of ant: If its			Cremation 3 🗆	Removal from State	Chîqu Guate	Miffi emal	chapa a	Y place	∍m ↓		29/04	Guat	juiri temal	ena a	rpa,
Balt	permit. Depart Import any inj		21. Signature 1 Fune	ral Service Liver	lle'							FUNER			•	P.A. Md20910
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R	Pnysician		Immediate Cause (Fir disease or condition	nal	. 15(u	NT FZ	Yce	Fr	ju	rie	0	ftee	a		0	nset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a consequence	9 of):		1	,						
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68760,	physic the b	edical			d											
Box 6		n/Me	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, outcome								23	3d. Date of d	elivery	
	death cert	Physiclan/M	in the past 12 mg	onths?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregi Other (speci						Month	Da	y Year
P.0	that the de led by the a detached	Phys	9 Unknown													
Vital Records,	es be	by	Part II. Other significa	ant conditions of	ontributing to death bu	at not resulting	in the ur	iderlying caus	se given	in Part I.		238. Did to			robab	cause of death? y 4 □Unknown
9 0 0	aw as b	Completed										24a. Was		24b. Were a	autopsy	findings available letion of cause of
<u> </u>	The la	Соп										perfo	rmed? 2□No	death?	,	□No
Vita	Phyaiclan: Th this certificate al director, pag	Be	25. Was case referred examiner?		Hospital:				Other:			(Check only o		77.5		
of	d is	To t	1 XYes 2 ☐ No 27. Manner of Death	0	28a. Date of Injur	y 28b.	outpatien: Time of		Injury a	ıt		ne 5 🗌 Resid		Other (Sp	ecify)	
ion	Attending Ir death. actor: After	atlor	1 ☐Natural 2 ☐ Accident	5 Pending investigation	(Month, Day	Year)	Injury	М	Work?	s 2	No	Suh	eit	bee	fa	N
Division	or Attendate death Diractor:	Certification;	3 ☐ Suicide 4 Safomicide	6 Could not be determined	28e. Place of Inju		farm, stre	et, factory, o	ffice		2	8f. Location (5 City or Tox	Street and vn. State)	Number or I	Rural P	oute Number,
	urs afte						7,00	Croi)			CM	non	N	
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1[(Check only 2[one)	Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examination a	ge, death ind/or inv	estigation, in	the time, my opin	, date an nion, dea	d place, a th occurre	nd due to the old at the time,	cause(s) a date and p	ind manner a place, and di	as state ue to th	ed. e cause(s)
1	To T com	Σ	29b. Signature and fit	le o certifie	0	\		29c. L	icense n					signed (Mor		
	V		30 No.	s of person who	meny opposite the same of	ath (ltar on-) (Tue - 1	Print)	C	O.C.N	4.E.		Octo	ber 2	1, 2	2004
			30. Namband address	- Ron C	completed cause of de	O LINE COLOR			n_St	reet	, Ba	ltimore	, Ma	ryland	<u> 2</u> 1	201
	Sta Registr		31. Date filed (Month, OCT		AF -	ar's Signature		Span								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 19, 2004 Bernard E. Statland 8:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 0 Ct. 21, 1941 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**∑**M 2□ F 62 468-46-2416 Minnesota Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-1 show other treumstic event, the Medical Examples must be notified at tv Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 209 Watkins Pond Blvd. 20850 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Item any injury on other treumatic event, I're Medical Exercitinal once. Black, White, etc. 1 Never Married 2 Married 1√ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Al Statland Beverly Mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandra Statland- Wife 209 Watkins Pond Blvd. Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/22/2004 Olney, MD Judean Mem. Gardens * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of/Funeral Service Licenses 11800 New Hampshire Ave. Silver Spring, MD 20904 pholu 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Anaplastic Astrocytoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Ž No 1 ☐ Yes 2 ☐ No 1 ☐ Yes after death.

Director: After this certific
I in by the funeral director, To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \boxtimes Other (Specify) HospiceHospital: 9 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 29c. License number D35635 October 20, 2004 10 son who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State OCT 25 2004

Registrar

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			For State Registrar		State	of Maryla	and / Depa	artment of rtificate of	Health Deat	and M h		giene Rog. No.	004	3	5550
			1. Decedent's Name (First, N	iddle, Las	t)						2. Date of De	ath	Vac		. Time of Death
	Physici /Medio				Mor	gan Le	on Stan	ley			October	Day 26			1:40a ^M
	Examir		4a. Facility Name (If not instit	ution, gîve	street and nu	ımber)		4b. City, Town,	or Locatio	n of Death		4c.	County of De	eath	
			Collingswood 1						ockvi				Mont	gome	ry
	Funeral		5. Social Security Number	6. Se	x XM 2□F		rs. last birthday)	If Under 1 Year Months Days		ler 24 Hrs. s Min.	8. Date of Bird (Month, Da	h y, Year)		Country)	(State or Foreign
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	and w		10a. State 10b. Co		-	10c.	City, Town or Lo	ocation						10d.	Inside City Limits
	Manyl f sho	ō	M1 1 M			D	-1								1 ☐ Yes 2 🖾 No
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	ns 2;	era	11. Marital Status	enue	12. Was Dec	edent Ever in	n U.S. 13.	Was Decedent of If Yes, specify Cul		Origin? (Spe	ecify Yes or No		ted Si		
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03	al', o	þ	3 ☑ Widowed 4 ☐ Divo	ced	If Yes, Gi Year or [oates:	100.000	1 ☐ Yes 2 🖾 No	Speci	ity:			Specify: V	Vhite	2
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pu	be fill d otl	Be	17. Father's Name (First, Mid								e (First, Middle,		Sumame)		
78	ould I Mer narke	P	Nat A. Stanle	•							L. Wedd				
Maryland	12 sh and n Is m	L	19a. Informant's Name/Related Roy L. Stanle					ng Address (Stree 4 Meadow.							
e,	1 and Fealth		20a. Method of Disposition	;y/ 3		201	b. Place of Dispo		Laik		oate I Jaille		cation - City		
Baltimore,	uges at of l		1 X Burial 2 ☐ Cremat				cemetery, cre	matory or other pla	ace)	10/0	2/2004		•		
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Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show entry injury or other treumatic event, the Medical Examination must be notified at ance.		21. Signature of Funeral Ser	LICEN:	21.11	4) [6	Name and Addr Lin L. M	olest	worth	P. A. 1	Tuner	al Ho	me	
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68	death certificate be executed e attending physician and nd for use as the burial-transit	edic			.										
Вох	that the death certification of the attending for the attending for the asset as	Physician/Me	IF FEMALE: 23b. Was decedent pregnan		23c. If yes, ou			35				2	3d. Date of c	delivery	
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	w requires that the sbeen signed by the should be detache	by P	Part II. Other significant cor	ditions co	ontributing to o	leath but not	resulting in the u	inderlying cause g	iven in Pa	rt I.	23e. Did to	obacco u	se contribute	to the ca	ause of death?
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0 4		ü	27. Manner of Death 1 X Natural 5 □ Pe	ndina	28a. Date (Mor	of Injury oth, Day Year	28b. Time o	f 28c. Inju	iry at ork?		28d. Describe I	iow injury	occurred		
<u>S</u>	Attending r death. ector: After	catl	2 ☐ Accident inv	estigation uld not be				M 1	Yes 2	□No					
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	termined	200. Place	e of Injury - A ling, etc. <i>(Spe</i>	it home, farm, sti ecify)	reet, factory, office			28f. Location (S City or Tox		Number or	Rural Ro	ute Number,
	urs af														
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier / 2 Med	itying Phy icel Exam	iner: On the t	pasis of exam	knowledge, deat iination and/or in	h occurred at the t vestigation, in my	ime, date opinion, c	and place, a leath occurr	and due to the e ed at the time,	cause(s) date and	and manner place, and d	as stated ue to the	i. cause(s)
	To the within 2 To the complex	Mec	29b. Signature and title of ce	tifier	and mar	ner stated.		29c. Licen	se numbe	or		29d. Date	signed (Mo	nth Day	Year)
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State of Maryland / Department of Health and Mental Hygiene, 35551 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AM 2004 1:30 October 1 HERMAN A. SANFORD /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner St Mary's 24370 Horseshoe Drive Clements If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 ☐ M 2 ☐ F **Funeral** Days Hours 1928 JAN 26 Washington, DC 76 Director 578-36-5175 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or items 23s or 28s-f show aminer roust be notified at 1 Tyres 2 □ No Frankford Delaware Sussex Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 19945 USA Route 2 Box 133 J Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status the Medical Examiner: a filed within 72 hours after did Hygiene. Other then "natural", or item Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Warehouse Employee Food Industry Pages 1 and 2 should be filled withment of Health and Mental Hygientant: If item 27 is marked other thiury or other traumatic event, the 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lula Richards Sanford Walter A. Sanford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Route 2 Box 133 J Frankford, Delaware Velma M. Sanford (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition GCremation 3 ☐ Removal from State 5 ☐ Other (Specify) 1 🗆 Buriai Metropolitan Crematory 10-23-04 Alexandria, VA Department of important: If eny injury or once. * 4 □ Donatio o Funer Service Licensee 22. Name and Address of Facility 21. Signature Eberwein Funeral Services MO0173 4433 White Pls. La. White Pls., MD 20695 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final Wd Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Security list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: use . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the. P.O. 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 1 Yes certificate 2 No Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: $_{4\,\square\, \text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) Daughters Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: Home Hospital or Attending 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral Completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 22, 2004 30. Name of Joddress of person who completed cause of death (Item 23a) (Type, Print) M.D. 2050 Wildwood Center California, MD 20619 Jennifer M. Schmidt, 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State · Suco OCT 2 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 20 35552 For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** OLIVE FRANCES HECKATHORN SNYDER OCT 23 2004 1:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Wilson Health Care Gaithersburg If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1911 Pennsylvania 92 Director 220-32-5221 DEC Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or Itams 23a or 28e-f shov Examiner must be rictified at 1 √Yes 2 No Gaithersburg Direct Maryland Montgomery 10e. Street and Number 301 Russell Ave. 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 2 and yi jury or other traumatic event, the Medical Exemples must be 1 and 2008. 20877 USA Village Funerai Asbury Methodist 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Corporate Secretary Family Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alice L. Slone Heckathorne 2 J.L. Heckathorne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12714 Country Lane Waldorf, MD 20601 Betty L. Lund (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)
21. Signature of Funeral Service Licentee Trinity Mem, Gardens 10-29-04 Waldorf, MD 22. Name and Address of Facility Eberwein Funeral Services M00173 4433 White Pls. La. White Pls., MD 20695 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence oi): **Physician** /Medical **Examiner** Dement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed funeral director, page 2 2 No certificate 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 DNO Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification: To 1 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 ☐ Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) in by t 4 Homicide filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P. Callahan-Lyon, mo 041794 October 232004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gaithersburg, MD 20279 911 1-Callatan - Lyon 31. Date liled (Month, Day, Year) 32. Refistrar's Signature OCT 2 5 2004 Registrar

		-	For State Registrar	State of M	iaryland	Cer	rtificate	of De	eath	IU IVI	, , , , , , , , , , , , , , , , , , ,	Reg. No.	20(]4	35553
	is is		1. Decedent's Name (First, Middle,	Last)			* :				2. Date of De	ath Day		Yeer	3. Time of Death
	Physici: /Medic	_	Thelma Elizab	oeth Startt	-						Octobe		_	2004	8:47 a ^M
	Examin	_	4a. Facility Name (If not institution, g	give street and number)		4b. City, To	wn, or Loc	ation of I	Death		4c.	County	of Death	
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B	Funeral			5. Sex 7. A 1 ☐ M 2 ☐ XF	ge (In yrs. las	t birthday) Yrs.	If Under 1 Months C			Min.	B. Date of Bir (Month, Da	y, Year)		9. Birthpl Count	ece (State or Foreign try)
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5-0036	within 72 hours after death with the Maryland ene. then *natural', or items 23e or 28a-f show the Medical Examiner must be notified at	d by	3 ☑ Widowed 4 □ Divorced									105 Kin	and set Day		
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Maryland	de la la		19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address (S	Street and I	Number	or Rurai	Route Numb	er, City o	Town, S	State, Zip	Code)
	1 and 2 Health a tem 27 is	10	Mason Startt Sr	/son		305	2 Litt	lesto	own 1	Pike	West	mins	ter,	MD	21158
ore	of He of He item r oth		20a. Method of Disposition 1 ☐ Burial 2XX remation 3	Removal from State	con	ce of Disponence	osition (Name matory or othe	of er place)		Da	ite	20c. Lo	cation - (City or To	wn, State
Ĕ	Pages ment of ant: If it	1	'4 □ Donation 5 □ Other (Spe		Carr	oll C	Cremati	on,]	Inc :	10/2	2/2004	Ha	mpst	ead,	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Li	censee		22 P	Name and Pritts	Address of Funer	Facility	Home	and C	hape	1. P	. A .	
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п			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause nly one cause on each	ed the death.	Do not ent	er the mode		110h 25 02	ardiac or					
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			State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and Natificate of Death	Mental Hygier	CUILLE	35554
	Physicia	an l	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
	/Medic		RICHARD JACOB ST		OCT. 19		4:25 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 1102 CANDY MINT LANE	4b. City, Town, or Location of Death WESTMINSTER	(4c. County of Death CARROLL	
Ŀ	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 9 1 - 1 8 - 6 6 8 2 12 M 2 F 8 2 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 7/15/19	ar) Cou	place (State or Foreign ntry) SYLVANIA
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ocation	·		10d. Inside City Limits
	Maryi -f sho lied a	tor	PA. NORTHAMPTON DANIEL	SVILLE			1 □Yes 2 No
	or 28e	Olrec	10e. Street and Number	10f. Zip Code		Citizen of What Cou	ntry?
	ath wi	rai	1093 MOSER RD.	18038		JSA	and the disc
2	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heathth and Mental Hygiene. After 18 marked other than "naturar, or items 23e or 28e-f show other traumatic avent, the Medical Examber in marked collider at	by Funeral Director	1 ☑ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WH]	etc.
3	2 hou		15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of work	ring 16b.	Kind of Business/In	dustry
7	vithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) MACHINIST		EEL MILI	
7	filed with Hygiene. Ithar thar Int, Ital	e Co	1 2 17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
	2 should be filed within and Mental Hygiene. Is marked other than aumatic avant, I.s. M.	To Be	JACOB A. STUBER	ESTE	LLA E. B	ROWN	
<u>a</u>	2 should and Men Is marke surnatic	_		ng Address (Street and Number or Rui			
	es 1 and 2 of Health of Health itam 27 I	17	THOMAS K. STUBER -NEPHEW 1102 20a. Method of Disposition 20b. Place of Dispo	CANDY MINT LAN		INSTER, Location - City or T	
			1 X Burial 2 Cremation 3 X Bemoval from State	matory or other place) MEM • PARK 10/2		•	
<u></u>	permit. Page Department of Importent: If any injury or once.			2. Name and Address of Facility FI			
ŏ	Depar Impor any ir		Jan Marken 2	54 E. MAIN ST.	WESTMIN		
ı	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ardiomysath	4		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	Costi	e Heart	12.0	. 0
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S	aw req	plete	Multisle Myeloma	0	24a. Was an autopsy	24b. Were auto	ppsy findings available
Ĭ	The late ha	Com	8		performed	death?	2 No
N II A	cian: sartific actor,	Be	25. Was case reterred to medical examiner?	O+	th (Check only one)		NEDHEWC
0	Physi r this o	- T	1 Tes 22 No 1 Inpatient 2 EH/Outpatier	of 28c. Injury at	ome 5 Residence 28d. Describe how in		NEPHEWS Home
0	nding th: :: After e fune	atlon	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time o Injury	Work? M 1 ☐ Yes 2 ☐ No		,	
DIVISION	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and the funeral director, page 2.	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stress building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	Hospit 24 hour Funara	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat (Check only one) Certifying Physician: To the best of my knowledge, deat (Check only one) and manner stated.	th occurred at the time, date and place, ivestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as s and place, and due t	tated. o the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month,	Pay, Year)
	MIL		> Trace L. Ryberg, D.O.	H006120	6 1	0/19/	2004
	MIR		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) UMC DRIVE W	150+ 1-	teo M	N 51100
			TRACE Ryberg D.O. 444 W 31. Date filed (Month, Day, Year) 32. Regignar's Signature	UMC DRIVE W	62 WINS	IEK, M.	21158
	Sta Registr		OCT 2 0 2004	1. 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
1- State Amend Item 23a pt.II,25,27,28a-I per me 645,7-19-05 tas

Certificate of Death

Reg. NO Reg. NO 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 000 Bailey Taylor Paul Det /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Legional Medical Center eninsula WICONICO If Unger 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min. 1**⊠**M 2□ F Months Director 185-28-6496 69 October 9, 1935 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nem zz re marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examinational be notified at TY Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 422 Hammond Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry 12 should ba filad within 7 h and Mental Hygiene. 7 Ie marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) unemployed 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walker ပ E. Taylor Marian Paul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) iges 1 and 2 s of Health an 30506 4436 Nautical Way, Gaincsville, Georgia Richard Taylor (brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) October 27, 2004 Salisbury, Maryland Salisbury Crematory 21. Si mature of Funeral Pervice Linnsee 22. Name and Address of Facility Holloway Funeral HOme Professional Association 501 Snow Hill Road, Salisbury, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, Due to for as a considuence of Examiner Tany, leading to in made cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last APPROVED BY MEDICAL EXAMINER burial-transit Due to (or as a consequence of): physician Box 68760 Physiclan/Medical as the b IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Left hip fracture 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed SCH1209 Fleet 2 🗆 No 1 Yes 1 Yes 2/2 No 25. Was case referred to medical examiner?

1 X Yes 2 No Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 28d. Describe how injury occurred Subject fell from standing 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: or Attending 1 Natural 2 X Accident 5 Pending investigation after death. 9-23-2004 2:45 1 ☐ Yes 2 X No height 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) LeHigh Day Program, Salisbury, MD 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} adult day program Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 10/19/04 110059368

State Registrar

V 31. Date filed (Month, Day, Year) OCT 2 2 2004

John Vaul

Garrell ST 100 E. 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

21804

		1	For State of Man		artment of Hortificate of L			2004	35556
	Physicia	an	1. Decedent's Name (First, Middle, Last) Robert Edward Tierney				2. Date of Death Month	Day Year 21 2004	3. Time of Death 8:20 A.M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	10	4c. County of Death	
	LAGIIIII		3414 40th Avenue		Bren	twood		Prince Ge	orge's
	Funeral		-₩	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Yuly 2, 1	(ear) 9. Birth	nplace (State or Foreign untry)
	Director	-	577-62-4846	57 Yrs.		J	uly 2, 1	.94 / Wash	nington, DC
	land	-		Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 sh	ţ	Maryland Prince George's	Brentwoo	od				1X Yes 2 No
	r 28a	irec	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	untry?
	th wit	a	3414 40th Avenue			722		U.S.A.	
	r dea	Funeral Director	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13.1	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
36	rs afte	by F	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ene. ttan "natural", or Itams 23a or 28a-f show ttan "Asiral Examinat reval be notitled at	ted	15. Decedent's Education	16a, Dece	dent's Usual Occupa	ition	16	6b. Kind of Business/	ndustry
215	hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)	uring most of working	9		
21	ad with	Con	12	Plumb	ing Inspe			O.C. Gover	nment
Maryland	be file tal Hy d oth avant	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		alden Sumame)	
<u>\</u>	ould Men narke	2	Morris Tierney 19a. Informant's Name/Relationship (Type, Print)	10h Maili		May Glass		City or Town, State, Z	in Code)
Mai	d 2 st th and 7 Is r traur		Mary Elizabeth Tierney - Wif					faryland 2	
ē,	Heal Heal tam 2		20a. Method of Disposition	20b. Place of Dispo		Da		Oc. Location - City or	
JOE TO	Pages ent of ht: If i		1 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)		ns Cemetery		/2004 0	heltenham.	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Itams 23a or 28a-1 show any injury or other traumatic avant, if the Model Examined must be notified at once.		21. Signature of Funeral Service Licensee			s of Facility Gas	ch's Fur	neral Home	, P.A.
Ö	Pe E E G		H Constance Ja	seh 4	739 Balti	more Ave.	, Hyatts	ville, MD	20781
H			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.					st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Stage	Renal	duser	1.		Chock and Doam
	/Medical Examiner		resulting in death) Due to (or as a continuous according to the continuous according	onsequents of):	101-	duren			
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8760	death certificate be executed e attending physician and of for use as the burial-transit	cal	d						
9	artifica ing ph e as th	Med	IF FEMALE:			-	10.00	- The state	
Вох	death certifica attending pt d for use as t	Physician/M	23b. Was decedent pregnant 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
0.		yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tir 9 ☐ Unknown 9 ☐ Unknown	10 of death 5L	Other (specify)				
٥	The law requires that the to the bas been signed by the bage 2 should be detache		Part II. Dther significant conditions contributing to death but	not resulting in the ε	ınderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	luires n sign lld be	d by	Hypertensin.				1 🗆 Yes	2000 3□Pr	obably 4 DUnknown
00	aw requir 1s been si 2 should	lete	Hypertensin. Hypertip, dema				24a. Was an	24b. Were au	topsy findings available
Re	The lavate has	Completed					autopsy performs 1 Yes 2	ed? death? ∑No 1 ☐ Yes	completion of cause of 2 No
Vital		Be C	25. Was case referred to medical examiner?			26. Place of Death	(Check only one,)	
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient			4 🗆 140131119 1 1011		ice 6 □Other (Spec	cify)
		iuo]	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury	Work		8d. Describe how	vinjury occurred	
isio	eat or:	icat	2 Accident investigation 3 Suicide 6 Could not be 3ee Place of Injury	r - At home, farm, st			8f. Location (Stre	eet and Number or Ru	ıral Route Number.
Division	i ditio	Certification	4 Homicide determined building, etc.				City or Town,	State)	
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai C	29a. Certifier (Check only one) 1X Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or in					
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier		29c. License		29	d. Date signed (Monti	
			1116600		15	374		10/21/0	24
P	15/11/		30. Name and address of person who completed cause of dea				200 =		D 00770
1	0/10	1			Center Dri	ve, Ste.	209, Gre	enbelt, M	5 20770
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 6 2004	s Signature	all a				
DI	MH 17 Pay 1/3		out we see your	F 149					

1		laryland / Depa	delible Ink. Ensure A artment of Health and M rtificate of Death	-	2004 3	35557
Physician (Medical	1. Decedent's Name <i>(First, Middle, Last)</i> Everett Bruc			October	24, 2004	3. Time of Death
Examiner	4a. Facility Name (If not institution, give street and number Harford Memorial Hospit 5. Social Security Number 213-16-9849 6. Sex 7. A		e (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		c. County of Death Harfor 9. Birthpla County 920 Penn	d ce (State or Foreign r) sylvania
	Usual Residence of Decedent 10a. State 10b. County Maryland Cecil	10c. City, Town or Lo	ocation Elkton	8. Date of Birth (Month, Day, Yea, May 19, 1		1. Inside City Limits 1 □ Yes 2⊠ No
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural, or Itams 23a or 28a-f show aumatic event, the Midical Examiner roust by notified at To Be Completed by Funeral Director	10e. Street and Number 150 Woods Way 11. Marital Status 12. Was Deceder	nt Ever in U.S. 13.	101. Zip Code 21921 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerfo		U.S.A. 14. Race - American	ı Indian,
J036 nours after de training to the training to the training de by Fund	Armed Force: 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates	□No s: 1942-45	1 ☐ Yes 2 ☑ No Specify:		Black, White, et Specify: Wh Kind of Business/Indu	ite
21215-0036 ed within 72 hours att vgjiene. in that "natural" or it, the Madical Exam! Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40) Twelve Years	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ainting Supervisor	V.	A. Medical erry Point,	Center
Maryland 3 nd 2 should be filed th and Mental Hyg 27 is marked othe ritraumatic event,	17. Father's Name (First, Middle, Last) unknown 19a. Informant's Name/Relationship (Type, Print)	19h Maili	18. Mother's Nam	ne (First, Middle, Maide unknov	wn	code)
Z 5 ∰ 2 €	Mabel E. VanHart (wife) 20a. Method of Disposition 1⊠Burial 2 □ Cremation 3 □ Removal from Sta	20b. Place of Disport cemetery, cre	Woods Way, Elkton,	Maryland Date 20c.	21921 Location - City or Tow 1ton, Penns	n, State
Baltimore, permit. Pages 1 a Department of Hes Important: If item any injury or othe	1 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License: 1 □ Other (Specify)	Lan Sr P	2 Name and Address of Facility ee A. Patterson & errvville. Marylar	Son Funera	al Home, P.	, A .
68760, Auticate be executed grown as the burial-transit ledical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	i line.	ter the mode of dying, such as cardiac	or respiratory arrest,	1	Approximate nterval Between Onset and Death UCCU
car car	IF FEMALE: 23b. If yes, outcor 23b. Was decedent pregnant 1□Live birth 1□Live birth	t at time of death 5	□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of deliven Month	y Day Year
	Part II. Other significant conditions contributing to deat	onavy art	cy discuse	1 🗆 Yes	o use contribute to the	bły 4 ∐Unknown
The ate h page	Nypertension Pros 25. Was case referred to medical	tate cance		24a. Was an autopsy performed 1 Yes 2 X	prior to com death?	sy findings available pletion of cause of
Division of Vital Records, To the Hospital or Attending Physician: The law requires t within 24 hours after death. To the Funeral Diractor: After this certificate has been signe completely filled in by the funeral director, page 2 should be Medical Certification; To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Hath Natural 5 Pending (Month, 2 Accident investigation 3 Suicide 6 Could not be	atient 2 ER/Outpatie njury Day Year) Injury - At home, farm, s, etc. (Specify)	ont 3 DOA Other: 4 Nursing H of 28c. Injury at Work? M 1 Yes 2 No	forme 5 Residence 28d. Describe how in	njury occurred and Number or Rural	
the Hospital thin 24 hours a thin 24 hours a the Funeral I mpletely filled	(Check only 2 Medical Examiner: On the basi one) and manner	s of examination and/or	ath occurred at the time, date and place nvestigation, in my opinion, death occu	irred at the time, date a	and place, and due to	the cause(s)
	29b. Signature and title of certifier 30. Name and address of person who completed cause	MNDO of death (Item 23a) (Type	29c. License number H 41069	Q _C	Date signed (Month, E	
State Registrar	DR. STANLEY KUMAN 130	8 BUSINESS	Center Way #10	2 Edge	wood =	21040

		1 - For State Registrar	State of Man	yland / Dep		lealth and M	lental Hygi	_		
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last, Alma Jo 4a. Facility Name (If not institution, give) 14568 Pansyl Va	street and number)			r Location of Death Prs foce n	2. Date of Death Month	Day Yea ZE ZO. 4c. County of De Wash.	04 11:43 AM	
Funeral Director		5. Social Security Number 6. Sec		n yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7/31/194	9. E 17 F	Birthplace (State or Foreign Country) Torida	
ne Maryland 8a-f show	ctor	10a. State 10b. County Maryland Washi	1	oc. City, Town or Lo Hager	stown			10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
3a or 2	al Dire	10e. Street and Number 14568 Pennsylva	nia Avenue		10f. Zip Code 2174	12	10	g. Citizen of What USA	Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydine. Department of Health and Mental Hydine. Importent: If them 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other treumetic event, the Medical Exaction of their treumetic event, the Medical Exaction of their contribution on once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	nerican Indian, hite, etc.	
d 2 should be filed within 72 hours aft in and Manual Hygiens aft in and Manual Hygiens fired from "natural", or treumetic event, the Medical Exert	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation (Give life. L		dent's Usual Occupi kind of work done of DO NOT use retired Homemak	during most of work d)	ing 1	6b. Kind of Busine Own h	ss/Industry	
should be file ind Mental Hy. marked other	To Be	17. Father's Name (First, Middle, Last) Benjamin Ad				Laura	e (First, Middle, M Mae Harv	vey		
nd 2 should alth and 27 is m		19a. Informant's Name/Relationship (Ty Willie Weakfall, J			ng Address (Street a					
permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State		g Cremato	ory 11/6	/2004 Sn		, MD	
permit. Departimport import eny inj		21. Signature of Funeral Service Licens	Luis	2.0	2. Name and Addres 7 N. Park		_		ral Home In 7236	
American and Examiner Iransit he benial-Iransit he burial-Iransit	Ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C								
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 [4□Pregnant at tirn 9□Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of o	delivery Day Year	
quires that I n signed by uld be deta	by	Part II. Other significant conditions con	ntributing to death but r	not resulting in the u	nderlying cause give	en in Part I.		/	to the cause of death? Probably 4 □Unknown	
siclen: The law requires to contificate has been signed rector, page 2 should be of	Completed						24a. Was an autopsy perform	ed2 prior to	autopsy findings available ocompletion of cause of ?	
Physicien: This certificate ral director, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	4EEE0	ot 3C DOA Othe		h (Check only one,) nce 6 Other (Sp		
rthis Pt	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time o Injury	f 28c. Injury	at raising no	me 5 A Residen 28d. Describe how		oecity)	
tel or Attending rs after death. el Director: Afte ed in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (Specify)			City or Town,	State)	Rural Route Number,	
e Hospitel or 24 hours afte e Funerel Dir letely filled in	edicai	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of n iner: On the basis of ex and manner stated	amination and/or in	h occurred at the tim vestigation, in my or	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner te and place, and d	as stated. ue to the cause(s)	
To the k within 2 To the f complet	Me	29b. Signature and title of certifier	an 1		29c. License		290	d. Date signed (Mo	nth, Day, Year)	
		30. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Typa		41667		11.1.	04	
3		Michael M	Corneck	1/10	Mela	wel Can	x v. 10	Locku	n MO	
Sta Registr		31. Date filed (Mooth, Day, Year)	32. Registrar's	Signature 4	1					

Physicia		1. Decedent's Name (First, Middle,	Last)		-		2. Date of Death Month		3. Time of Death		
/Medic		AARON T. WAUDI	BY				NOVEMBER		7:58A. M		
Examin		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, Town, or	Location of Deat	h	4c. County of I	Death		
		29696 TALLULAH L			EASTO			TALBOT			
uneral irector		213-15-6507	5. Sex 1 M 2 □ F	Age (In yrs. last birthda 24 Yrs.	Months Davs	Hours Min.	8. Date of Birth (Month, Day, MAR 20	Year) 1980	Birthplace (State or Foreign Country) UTAH		
A T	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
23a or 28a-f show ust be nutitied at	ō	MD TALBO	ידי		EASTON				1∭ Yes 2 No		
28a-f	Director	10e. Street and Number	71		10f. Zip Code		10	Og. Citizen of Wha	at Country?		
23a or	<u></u>	29696 TALLULAH	I LANE		2	21601		US.	1		
	Funeral	11, Marital Status	12. Was Decede	ent Ever in U.S.	Was Decedent of Hi If Yes, specify Cuba		pecity Yes or No-	14. Race - A	American Indian,		
al', or Itams Examiner m	þ	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Force d 1 Tyes 2 If Yes, Give Year or Date	K) No	1 ☐ Yes 2 ☐ XNo	Specify:	o rican, etc.)	Specify:	White, etc. WHITE		
	Completed	15. Decedent's (Specify only highest		16a. Dec	cedent's Usual Occupa	ation	rkina	16b. Kind of Busin	ess/Industry		
1756	du	Elementary/Secondary (0-12)	College (1-4	life	DO NOT use retired	1)	9				
other than ant, the M	So	12	1	SA	LES ASSOCI			FFICE SU	PPLY		
evant,	Be	17. Father's Name (First, Middle, La				18. Mother's Nar	me (First, Middle, M	Maiden Sumame)			
markad o	၉	THOMAS A. WAUI					E_HUTCHIN				
8 6		19a. Informant's Name/Relationshi			ailing Address (Street a						
item 27 other tr		THOMAS A. WAUDBY	/ FATHER		96 TALLULA	H LANE E					
		1 Durial 2 Toremation 3 Removal from State cemetery, crematory or other place)									
Department Important: If any injury o	`4 □Donation 5 □Other (Specify) CHESAPEAKE CREMATION CTR.11-6-2004 STEVEN										
		21. Signature of Funeral Service Li	Z. ME	RIERON	ELLOWS, H	ss of Facility IELFENBEI RISON ST	N & NEWNA	AM FUNERA	AL HOME PA		
ej.		23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that cau	sed the death. Do not e					Approximate Interval Between		
hysician /Medical xaminer		Immediate Cause (Final disease or condition		Onset and Death							
		resulting in death)		ic ketoacid							
			Due 10 (01	as a consequence of):	0313						
				as a consequence of):	0313						
	Jer	Sequentially list conditions, if any leading to immediate	b	as a consequence of):	0313						
nd ransit	aminer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b		0313						
an and rial-transit	Examiner	Sequentially list conditions, if any lead in termination cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		0313						
ysicia ne bur	cal	that initiated events	b	as a consequence of):	0313						
ysicia ne bur	cal	that initiated events resulting in death) Last	b	as a consequence of):	0313						
ysicia ne bur	cal	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b. Due to for c. Due to (or d. 23c. If yes, outco	as a consequence of): as a consequence of): me of pregnancy				23d. Date of			
ysicia ne bur	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to or c. Due to (or d	as a consequence of): me of pregnancy 1 2 Fetal death 1 at time of death	3□Ectopic pregnancy			23d. Date of Month	f delivery Day Year		
by the attending physicia tached for use as the but	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to for c. Due to (or d. 23c. If yes, outco	as a consequence of): me of pregnancy 1 2 Fetal death 1 at time of death	3∐Ectopic pregnancy						
ed by the attending physicia detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to or	as a consequence of): me of pregnancy 12	3 □Ectopic pregnancy 5 □ Other (s <i>pecify</i>)		23e. Did tob.	Month			
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certificate has been signed by the attending physicia rector, page 2 should be detached for use as the bur	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to for c. Due to (or d. 23c. If yes, outco 1	as a consequence of): as a consequence of): me of pregnancy 1 2 Fetal death 2 tat time of death 2 th but not resulting in the	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) e underlying cause give	en in Part I.	1 Yes 24a. Was an autopsy perform 1 Yes 2	Month acco use contributes 2 \(\text{No} \) 3 \(\text{Signature} \) 1 24b. Were prior deat (eat) (Day Year te to the cause of death? Probably 4 Unknown e autopsy findings available t to completion of cause of the Yes 2 No		
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fler this certificate has been signed by the attending physicia ineral director, page 2 should be detached for use as the bur	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 1 Suicide 6 Could no determin 29a. Certifier 1 Certifying	b. Due to lor c. Due to (or d. 23c. If yes, outco 1 Live birtl 4 Pregnan 9 Unknow as contributing to deat Hospital: 1 Inp 28a. Date of (Month, tition 28e. Place of building	as a consequence of): me of pregnancy n 2 Fetal death it at time of death it the but not resulting in the catient 2 EP/Outpat Injury Day Year) Injury - At home, farm, n, etc. (Specify) est of my knowledge, de	3 Ectopic pregnancy 5 Other (specify) e underlying cause give bient 3 DOA Other of 28c. Injury work 1 Street, factory, office	26. Place of Dea er: 4 □ Nursing H r at c? Yes 2 □ No	24a. Was an autopsy perform 1 Yes 2 ath (Check only one 5 Resider 28d. Describe how city or Town, and due to the call and due	Month acco use contributes 2 \(\text{No} \) 3 \(\text{Total of } \) 24b. Were prior deat (eat and Normber of State) Weeks) and Number of State)	Day Year te to the cause of death? Probably 4 Unknown e autopsy findings available t to completion of cause of the Specify) SCENE Or Rural Route Number,		
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		-	State of Maryland / Dep 1 - State 10-26-04 Registrar Amend#'s 25.27.28af.Per ME PGCC	artment of Health and Me artificate of Death	ental Hygie	ne2004	35560			
Ne	Physicia	an	Decedent's Name (First, Middle, Last) Ruby Bradley Williams		2. Date of Death Month September 2	Pay 2004 ^{Year}	3. Time of Death 1:22 A. M			
>	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Prince George's				
	Funeral		Southern Maryland Hospital Center 5. Social Security Number	Clinton If Under 1 Year If Under 24 Hrs.	1	,	place (State or Foreign			
	Director		064-24-8226 1□M 2気F 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye February 17	7, 1921 Sou	ffi Carolina			
	yland sow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits			
	Se-f sh	Director	Maryland Prince George's	Suitland		1 XYes 2 ☐ No				
	with the		10e. Street and Number 3857 St. Barnabas Road #I-1	10f. Zip Code 20746	Citizen of What Cou U.S.A.	ntry?				
	ame 2	Funerai		Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,				
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or Itame 23a or 28e-f show edoth, I'm Medical Examinar must be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ② No If Yes, Give Year or Dates:	1 ☐ Yes 22 No Specify:		Specify: B	lack			
15-0	- 3	letec	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	g 16b	. Kind of Business/In	dustry			
212	filed within Hygiene. Ither than "	Completed	Flamantary/Secondary (0-12) College (1-4or 5+)	eccunting Assistant		1.U.D.				
and	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, Italia	Be	17. Father's Name (First, Middle, Last) William Green Bradley, Sr.	18. Mother's Name	(First, Middle, Maio Lottie Rose					
Maryland	is 1 and 2 should be of Health and Mental item 27 is marked of other treumatic even	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural						
	1 and Health iem 27	1	20a Method of Disposition 20b. Place of Dis	St. Barrabas Road #T-2		Location - City or To				
mo	0 0		I AMBURAL 2 Cremation 3 Removaliton State		malory or other place) 1 National Cemetery 9/28/04 SUitla					
Baltimore,	permit. Pag Department Importent: I any Injury o		10 10	22. Name and Address of Facility Ro 339 Hunt Place, N.E. Wa		al Home, In	c.			
			23a. Part. Enter the disease, or complications that ceused the death. Do not e				Approximate Interval Between			
	Pnysician /Medical	8 9	Infinediate Cause (Final disease or condition a. CORONEY resulting in death)	AvTery Dis	925E		Onset and Death			
ľ	Examiner		Due to (or as a consequence of)	1 exton	77					
	ed sit	niner	Sequentially list conditions, if any leading to immediate causes. Enter Underlying Cause (Disease or injury	1/16 353						
oʻ	sate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):	Av Tery Des						
8760,	icate be physicial s the bu	dicai	d	7						
ox e	eath certific attending p	ın/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv				
O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me		Other (specify)		Month	Day Year			
٩	igned by	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to t				
Records,	w require been sig should b		Left Hip traclure	<u> </u>	1 ☐ Yes					
Rec	The law	Completed	Retranguitages (Hem	eTome	autopsy performed	l? death?	opsy findings available ompletion of cause of			
Vital	Physician: The this certificate ral director, pag	25. Was pass? 26. Place of Death (Check only one)								
of	8 5	7: To	17 Yes 2 Hospital: 1 Appatient 2 EP/Outpati 27. Manner of Death 28a. Date of Injury, 28b. Time	of 28c. injury at 2	ne 5 ☐ Residence 8d. Describe how i		(h)			
sion	ending sath. or: Afte	atio	ZA ACCIDENT	O M 1 Tes 2 € No	how					
Division	or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		81. Location (Stree City or Town, S COTL Sce	t and Number or Run tate) 3 857 S	al Royle Number DANALOES AND AND EL			
	To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral of	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated	ath occurred at the time, date and place, a	nd due to the caus	e(s) and manner as s	stato.			
	Fo the within 2 Fo the somple	Med	29b. Signature and title of entifier	29c. License number	29d.	Date signed (Month,	Day, Year)			
			1 Potille MD	D19889	Se	pT-22-	04			
P	(5)		30. Name and andress of person who completed cause of death (Item 23a) (Typ		Ave SE	DC	20032			
	Sta		31. Date filed (Month, Day, Year) 2. Registrar's Signature			, , , ,				
	Regist	rar	OCT 2 6 2004							

			For Stata Registrar			State	of Man	yland				lealth a Death		lental Hy	_	001	•	355	61-
			Decedent's Name	First, Middle	e, Last)			-						2. Date of De Month			əar	3. Time of	
	Physicia /Medic		Connie	Ba	ites		Wi1	.liam	າຣ					Octobe		1, 20		10:20	AM
	Examin	er	4a. Facility Name (It	f not institution	n, give st	reet and r	number)			4b. City	Town, o	r Location				County of [
		Щ	Salisbur 5. Social Security N		sing 6. Sex	and			iter st birthday) If Linde	r 1 Year		isbu 24 Hrs.	ry, Md.		Wicom		non /Ctntn n	- Foreign
П	Funeral Director		194-20-86			м 2 Х F		84	Yrs.	Months	Days	Hours	Min.	Month, Da	y, Year)			ace (State of	r Foreign
-	ס		Usual Residence of	Decedent									1	WDLIT I	4/ L	920		tucky	
	show	_	10a. State	10b. County			1	oc. City,	Town or L	ocation							10	d. Inside Cit	
	Ba-f	ecto	Maryland	Wicon	nico			Heb	ron_	- T								1 🗆 Yes	2 <u>[X]</u> 140
	with t	Funeral Director	10e. Street and Nur	nber						10f. Zi	Code				10g. Citi	zen of Wha	it Count	ry?	
	leath	era	6865 Fire	etower			ecedent Eve	er in U.S.	. 13.	Was Dece	21830 dent of H) Iispanic Or	iain? (Sp	ecify Yes or No	je 1	USA 14. Race - /	America	an Indian,	
(0	r Iten	표	1 Never Marri	ied 2 🔀 Mar	nied	1 ☐ Ye:	Forces?							ecify Yes or No Rican, etc.)		Black, V	White, e	etc.	
ğ	ral', o	i by	3 Widowed	4 Divorced		If Yes, (Year or	Dates:			1 🗌 Yes	201 No	Specify:				Specify:		White	
21215-0036	within 72 hours after death with the Maryland ene. Than "natural" or Items 23a or 28a-f show the Medical Examinatin unit to molified al	Be Completed	(Spec	15. Deceden	t's Educa st grade	ation com <i>plete</i>	d)		16a. Dece (Give	dent's Usu kind of wo	al Occup ork done	ation <i>during</i> mos d)	t of work	ing	16b. Kir	nd of Busin	ess/Ind	ustry	
12	within	Id m	Elementary/Seco	ndary (0-12)		College	(1-4or 5+)					" Prov			Llome	Dave	Car	e Pro	i don
р Б	filed v Hygie ther t	ပ္	17. Father's Name	(First, Middle,	Last)				HOME	Day	Jare			e (First, Middle,			Car	e PLO	vraer.
an	id be ental ked o	To Be					Do	tes				N6 -					TT _ 1	1 7	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of health and Mantle Hygiene. Department of health and Mantle Hygiene. Department of the m 27 la marked other than "natural", or thems 23a or 28a-1 show any injury or other traumatic event, the Maritral Experiment must be notified at once.	-	Hancey 19a. Informant's Na	ame/Relations	hip (Typ	e, Print)	Da	ites	19b. Mail	ing Addres	s (Street	and Numb	ggie er or <i>R</i> un	al Route Numbe	ər, City or	Town, Sta	Ha. te, Zip	Code)	17
ž	and 2 alth a 1 27 le er tra		Kim Ward	(gran	ıddaı	ıghte	r)		113 1	Middle	eton	Plac	e, M	oresvi	lle,	Nort	h Ca	arolin	a a
altimore,	of He of He fiter		20a. Method of Disp		3 □₽4	moval fro		20b. Pla	ce of Disp netery, cre	osition (Na matory or	me of other plac	ce)	(Date	20c. Lo	cation - City	y or Tov	wn, State	
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Balt	ermit. Pepart nport ny inj nce.	-	21. (ignature of Fu	ner I Service	License	8			2			ss of Facili Fune		Home Pr	ofes	siona	1 As	ssocia	tion
	⊄ □ = @ QI		David.		buch			FSf		501	Snow	Hill	Road	d, Sali	sbury	y, Ma	ryla	and 2	1804
Į,	ST 18			rt failure. List	only one	cause or	n each line.	e death.	Do not er	iter the mo	de of dylr	ng, such as	cardiac (or respiratory a	rrest,			Approximate Interval Bety Onset and D	veen
	Physician /Medical		Immediate Cause (disease or conditio resulting in death)	(rinai in	_ a.	10	l-	12	org	/	if	0-	r					4 00-	>
r	Examiner					Due	to (or as a c	conseque	ence of	/							1.		
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8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physiclan/Medical			d.												_		
<u>3</u>	eath certific attending p	Med	IF FEMALE:		00	a lévea					-								
Box	attend for us	lan/	23b. Was decedent in the past 12		23	1 Live	outcome of points of the birth 2 [Fetal d	léath 3i	Ectopic p		1			2	3d. Date of Month		,	ear
o.	the de	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown			9 Uni	gnant at tin known	ne or dea	ıın 5	Other (s	оөспу)								
Ω.	that ed b deta		Part II. Other signif	icant conditi	ons cont	ributing to	death but r	not result	ing in the	underlying	cause giv	en in Part I		23e. Did t	obacco us	se contribu	te to the	a cause of de	eath?
rds	law requires as been sign 2 should be	ed by												10	Yes 2	No 3	Proba	ıbly 4 ∏U	nknown
000	aw require s been si 2 should b	olete												24a. Was		24b. Wer	e autop	sy findings a	vailable
æ	9 L B	Completed												autor perfo	rmed?	deat	no com h? Yes :	npletion of ca 2 □ No	use or
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sio	Attending is death. ector: After by the funer	icat	2 ☐ Accident 3 ☐ Suicide	investi	not be	200 010	oo of Injune	. At hom	o form o	M		Yes 2□		28f. Location (S	Stroot and	1 Number o	r Dural	Poute Numb	bor
Division	I or Atteno after death Director: I in by the	ertification:	4 Homicide	detem	nined	bui	ice of Injury ilding, etc. ((Specily)	10, (4)111, 5	reet, ractor	у, опісе			City or Tov		7 Adilipal o	r Hurai	HOOTE WAITE	Jer,
	e Hospital or 24 hours afte e Funeral Dir etely filled in	O	29a. Certifier	1 Certifyii	ng Physi	ician: To I	the best of r	my knowl	ledge, dea	th occurred	at the tir	ne, date ar	nd place.	and due to the	cause(s)	and manne	r as sta	ited.	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only one)	2 Medical	Examin	er: On the	basis of example basis	xamınatic	on and/or i	nvestigation	n, in my o	pinion, dea	th occurr	ed at the time,	date and	place, and	due to	the cause(s)	
	To the twithin 24	Me	29b. Signature and	title of certifie	or /	1/				29	c. Licens	e number			29d. Date	signed (M	fonth, E	Day, Year)	
)			1	7	4//	Las				0	2	-93,	1		/	1/2/	100		
3)		30. Name and addr		who con	npleted ca	ause of deat	th (Item 2	23a) (Type	, Print)		200	11	3 Avro 6	0.14	hum	na -	1	
\bigcirc			Willia 31. D21 80 4100	Im H	. K	i do	n S, L Registrar's	M.	0			200 (~rV1(Ave.,	od118	soury	, IIC	1 •	
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				State of Ma	aryland / Depa <i>Cel</i>	artment of rtificate o			iene 004	35562	
	Physicia /Medic		Decedent's Name (First, Middle, Last) NARCISSUS	G. Wi	HITLEY			2. Dete of Dee Month OCT	Dey Year 23 2004	3. Time of Death 6:30PM	
	Examin		4e Fecility Neme (If not institution, give s BRADFORD OAKS		HOME		4b. City, Town, or CLIN	Location of Death			
	Funeral Director		Sociel Security Number 6. Sex		(In yrs. last birthdey) 86 Yrs.	If Under 1 Yea Months Day	r If Under 24 Hrs	8 Date of Birth		rthplace (State or Foreign ountry) J • C •	
	pue »		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	Maryler a-f ahow	tor	MD. P.G.		•	STVILL	E			1 X Yes 2 □ No	
	ath with the Maryler 123a or 28a-f ahow wat be notified at	I Direc	10e. Street end Number 1600 ADDISON R	OAD SOUT	TH	10f. Zip Code	0747	1	0g. Citizen of Whet C	ountry?	
36	or item	by Funeral Director		2. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:1	ever in U,S. 13. 1	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2X N	Hispanic Origin? (Sben, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	te, etc.	
21215-0036	- 2	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Deced (Give	tent's Usual Occ kind of work don DO NOT use retii	upation e during most of wo ed) MTST	orking	16b. Kind of Business	/Industry	
	should be filed within Ind Mental Hygiene. marked other than Imatic event, the Mental Indiana.	To Be Co	12 17. Father's Neme (First, Middle, Last) CLAUDE GODWI	N				me (First, Middle, M	PVT Maiden Surname)		
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	ges 1 and it of Health If item 27 or other to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	<u> </u>	20b. Place of Dispo				20c. Location - City or	MD. 20747 Town, State	
Baltimore,	permit. Peges 1 end Depertment of Health Important: If ther 27 any Injury or other to once.		4 Donetion 5 Other (Specify) 21. Signature of Fune al Service License	е	Quantico 22	. Name and Add	ress of Fecility	_10-29-04 VATSON F		e, Va.	
	20.240	_	23a. Part1. Inter the disease, or complic	eations that caused t	the death. Do not ent		4th ST.		net	Approximate	
	Physician /Medical Examiner		23a. Part1. Inter the disease, or complications, for heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ATHE	ROSCEAC	71C	CARDIO	VASCUL	AL	Interval Between Onset and Death	
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oʻ.	execute an end nel-trans	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	C	Due to (or es a conseq	uence of):					
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	thet the death cered by the attendindeteched for use	sicia	Part II. Other algnificant conditions conf	ributing to death but	not resulting in the ur	nderlying cause g	iven in Part I.	23b. Did to	bacco use contribute	to the ceuse of death?	
s, P.O	es thet the igned by t be detect	by Physician/M	CEREBROVATOU	MR A	eciden	P		1 □ Ye	es 2□No 3□P	robably 40-86hknown	
of Vital Records,	aw requir as been s 2 should	Completed	DIABETES					24a. Was er perform	ned?	Were autopsy findings available prior to completion of cause of death?	
ial H	ilcian: The certificete I rector, page		25. Was case referred to medical					1176		1 ☐ Yes 2 ☐ No	
f Vii	Physician: this certific ral director,	To Be	examiner?	ospital:	t 2 ER/Outpatien	t 3□ DOA O	hor /	ath <i>(Check only one</i> dome 5 Reside		cify)	
	ding Phi th. After thi funeral		27. Menner of Death 1 SMaturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey	Year) 28b. Time of Injury	28c. Inje W M 1[28d. Describe ho		,,	
Division	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,	
	the Hospital hin 24 hours the Funeral I npletely filled	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of er: On the basis of e end manner stete	examinetion end/or inv	occurred et the t estigation, in my	ime, date and plece opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)	
	To the To the comple	_	29b. Signature and title of certifier	PHY814			se number 78		OCT 26	h, Day, Year) th 200 4	
R	[8]		30. Name and address of person who cor	npleted ceuse of dea	ath (Item 23e) (Type, F	Print)	-	TE #101			
	State Registra	Ç	31. Dete filed (Month, Day, Year)	32 Registrar		ZIOIA L	SV CVI	10 /1/01) FI- U	MD	

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 2:00 PM JOSEPH YONKE OCTOBER 10 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner CAROLINE DENTON CAROLINE NURSING HOME Birthplace (State or Foreign Country)
 NEW YORK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Days Hours Months 1√□ M 2□ F Yrs 86 Director 054-10-1441 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Merylend 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at ty⊡Yes 2□No Director EASTON TALBOT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21601 13 CURZON COURT Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Š 3 Widowed AD Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WAVERLY PRESS PRODUCTION MANAGER 12 permit. Pages 1 and 2 should be filed Department of Health and Mantal Hygi Important: If Item 27 Is marked other sny Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANNA VONCINI JOHN YONKE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31350 MILLER RD., CORDOVA, MD 21625 PHYLISS WILLIS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 10-11-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 OHN MERCERON 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.
To the Zerneral Director: After this certificate has been signed by the attending physician and completely filled in by the funceral director, page 2 should be dateched for use as the buriat-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 25/N 1 ☐ Yes 2 ☐ No 1 TYes Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Leath 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Anaturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) 920 market St. Denton, mD 31. Date filed (Month, Day, Year) 32. Registrer's Signature State UU Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 7 2004

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State of Maryland / Department of Health and Mental Hygiens	And the feet we have
State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 0 0 4	35565

Physician /Medical Examiner
Funeral

Director . Pages 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. The strength of the marked other than "natural", or Items 23a or 28a-f show jury or other traumatic event, Item Medical Examinating minister and item at

Director

Funeral

9000	s 1 and 2 should be filed within 72 hours aft f Health and Mental Hygiene. item 27 ie marked other than "natural", or other traumatic event, the Medical Evard	d by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 📉 Xio		
215-	in 72 h	Be Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of workingd)	ng 16
212	d with giene er the	mo;	12th grade	College (1-401 54)	Uhemploye	d	
b	e file al Hy l othe vent,	3e C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma
<u>la</u>	wild b Ments arked	To	Jimmie Ya	ites			Caleathia V
an	2 sho and ie ma		19a. Informant's Name/Relationship (7		19b. Mailing Address (Street		
≥, ≤	and sealth n 27		Mattie E. Wilcox (Gra		4620 Hanna Place		
Baltimore, Maryland 21215-0036	(A U		20a. Method of Disposition 1XXSurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	rlace of Disposition (Name of emetery, crematory or other pland mony Memorial Part	ice)	27,2004 1
Balt	permit. Page: Department or Importent: If i any injury or once.		21. Signature of Funeral/Gervice Licen	nderson		LACE, N.E. WA	
			23a Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the deatl	n. Do not enter the mode of dyi	ng, such as cardiac or	r respiratory arres
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Mulli Due to (or as a conseq	ple gr	msho	7 wa
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):		
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Division of Vital Records, P.O. Box 68760,	Itel or Attending Physicien: The law requires that the death certificate be executed us after death. The task been signed by the attending physician and rel Director; After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-transitian in by the funeral director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopic pregnand		
ds, P.	uires that t signed by d be detac	d by Ph	Part II. Dther significant conditions co	ontributing to death but not res	ulting in the underlying cause gi	ven in Part I.	23e. Did toba
Recor	ne law requ has been ge 2 shoul	mplete					24a. Was an autopsy
a	n: Th ficate or, pag	CO	25. Was case referred to medical			00 81	1 XYes 2
5	aicle s certi	To Be	examiner? TY Yes 2 No	Hospital: 1 ☐ Inpatient 2 🛭	ER/Outpatient 3☐ DOA Ot	26. Place of Death her: 4 \(\sum \) Nursing Hom	
of	g Phy er this eral o	n: T	27. Manner of Death	28a Date of Injury	28b. Time of 28c. Inju		8d. Describe how
ion	nding ath. r: Att	ertification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	FOUND 10/21/04	Found A M	Yes 2 No	Deceau
vis	Atte acto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factory office	2	81. Location (Stre City or Town,
	tel or rs aft el Dii	Cer		S	treet		WASH.
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical			wledge, death occurred at the t tion and/or investigation, in my		
	To t To t	Σ	29b. Signature and title of dertifier	11.	29c. Licen	se number	290
	7		XHUV	N		OCME	C
R	4)		30. Name and address of person who	completed cause of death (Item	1 23a) (Type, Print) 111	Penn Stree	t, Balti
	Sta	ite	31. Date filed (Month, Day, Year)	39 Registrar's Signa	iture		

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 21, CARLOS E. YATES 2004 0230 A. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 DKM 2 □ F 577-02-1165 December 5,1971 Washington, D.C. Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐¥es 2 ☐ No Washington D.C. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4620 Hanna Place, S.E. 20019 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes ZXNo If Yes, Give 1 X Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Unemployed N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jimmie Yates Galeathia Wilcox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mattie E. Wilcox (Grandrother) 4620 Hanna Place, S.E. Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park October 27,2004 Landover, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL HOME, INC. ION, D.C. 20019 Approximate Interval Between Onset and Death ry arrest, 23d. Date of delivery Month

Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2 □ No autopsy performed? es 2 No

Residence 6 Other (Specify) ribe how injury occurred

eased on (Street and Number or Rural Route Number of Town, State) 5000 H Street, SE

D.C. the cause(s) and manner as stated. ime, date and place, and due to the cause(s)

29d. Date signed (Month, Dey, Year)

October 21, 2004

altimore, Maryland 21201

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			1 - State of Marylar State of Marylar Registrar	nd / Depa <i>Cei</i>	artment of Health and Martificate of Death	lental Hygie	ene 2004	35566
I	Physici /Medio		1. Decedent's Name (First, Middle, Last) Sw HV11 YEE			2. Date of Death Month	Day Year	3. Time of Death 0900 \$ M
	Examir		4a. Facility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, or Location of Death Bethe	eda	4c. County of Deeth Montgom	ery
	Funeral Director		5. Social Security Number 231-86-7173 6. Sex 1 M 2XXF 65	. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Dec. 10, 1	9. Birthe Cant	place (State or Foreign ntry) Con China
	aryland ahow	_		ity, Town or Lo			1	10d. Inside City Limits
	with the M 3a or 28a-f	Funeral Director	Maryland Montgomery Si 10e. Street and Number 2300 Eccleston Street	lver Sp	oring 10f. Zip Code 20902	10g	J. Citizen of What Cou	1 □ Yes 2 ¬No
36	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 ahow Jisal Examinar rust be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Uarmed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ĺ.	Vas Decedent of Hispanic Origin? (Spo f Yes, specify Cuban, Mexican, Puerto I □ Yes 2 ∰ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23s or 28s-f ahow may injury or other traumatic avant, the Medical Examiner must be notified at ance.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	lent's Usual Occupation kind of work done during most of worki OO NOT use retired)	ng 16	Sb. Kind of Business/In	
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	ges 1 and t of Health If itam 27 or other t		May Yee Downum (Daughter) 20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 3 □ Removal from State	_			c. Location - City or To	
Baltimore,	permit. Pag Department Important: any injury once.			22	shington Cemetery Name and Address of Facility Le			
Ē,			23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.		6633 Old Alexandri. or the mode of dying, such as cardiac c			Approximate Interval Between Onset and Death
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Divis	tal or Attanders after deatlal Director:	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At h building, etc. (Special Could not be determined 28e. Place of Injury · At h building, etc. (Special Could not be determined 28e. Place of Injury · At h	ome, farm, stre	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura. State)	l Route Number,
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	To tha within To tha comple	2	29b. Signardre and title of certifier		29c. License number D29675	29d.	Date signed (Month, I	Day, Year)
7	B3		30. Name and address of person who completed cause of death (Item BoxUs 6400 K	algosp	or Dv. Benjany	y hoz	20817	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 6 2004 32. Pristrar's Signa	iture /	(ca)	, ,		

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	Div ! - !		1. Decedent's Name (First, Middle	ə, Last)						2. Date of Death Month	Davi	V	3. Time of Death
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	Examir		4a. Facility Name (If not institution				4b. City, Town, or	Location o	f Death		4c. County of		
			Shady Grove	Adventist	Hospita	a1	R	ockvi	111e		М	ontg	omery
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🕅 F	7. Age (In yrs. Ia	ist birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Y			place (State or Foreign
	Director		141-68-5338	1 M 2 M F	49	Yrs.	Wioritis Days	110013		October 1,	1955	Cour	"India
	p a		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Lo	antin a						
	sho	ž	, , , , , , , , , , , , , , , , , , , ,		100. Oity,	TOWIT OF LO	cation						10d. Inside City Limits
	8a-f	Director		ntgomery			Montgom	ery V	/illa	<u> </u>			1 ☐ Yes 2 X No
	with t		10e. Street and Number				10f. Zip Code			10g	. Citizen of W	hat Cour	ntry?
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	er de Item	nue	11. Marital Status	Amed F	edent Ever in U.S orces?	5. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Orig n, Mexican,	in? (Spec , Puerto F	ofy Yes or No- lican, etc.)		- A <i>m</i> end , White,	ean Indian, etc.
99	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the MacCeal Examinar munitor mulling at	by F	1 ☐ Never Married 2 ☐ Marr 3 🔀 Widowed 4 ☐ Divorced	If Yes, G Year or I	2 No ive	1	☐ Yes 2X No	Specify:			Specify:		
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3	shound M	-	19a. Informant's Name/Relations.		, Rao	19b. Mailin	g Address (Street ar	nd Number	r or Rural	Kaveri Route Number, C			Code)
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ā,	f Healten		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of	-			c. Location - C		
5	age:		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from	MC	ntgom	atory or other place ery	' i	Nove 9, 2	mber	D . 1		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merital Hygiene. Department of Health and Merital Hygiene. Insportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and be notified at once.	1	21. Signature of Inneral Service		Cr		rium Inc. Name and Address	of Facility	9, 2	004 ort / D	Bethese	da,	Maryland
B	Dep any any		18/ 5	x //	MOOS	Be	thesda-Ch thesda, M	evy C	hase	do Inc. 7	\$57 WI	scon	neral Home/ sin Avenue
			23a. Part1. Enter the disease or	complications that	caused the death.	Do not ente	er the mode of dvina	aryıa . such as c	ardiac or	respiratory arrest	1		Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	a				roopiiatory arroot	•		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	arry Min							-1	minuks
	Examiner			Due to	(or as a conseque	,							
	4 2 3	ĕ	Sequentially list conditions, if any, leading to immediate	b. Due to	(or a conseque	ence of):						-	year,
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V ,"	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseque								gu -
8760,	icate be executed physician and s the burial-transil	dlcall		d									
	ificat g phy as the	au I		U									
ROX	law requires that the death certificate been signed by the attending to should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnan						23d. Date	of delive	erv
ň	death a atte d for	icla	in the past 12 months?	4□Pregi	pirth 2 ☐ Fetal on mant at time of dea		Ectopic pregnancy Other (specify)				Mont		Day Year
9	at the de by the a tached t	Jys	9 Unknown	9□ Unkn	own								
7	res that igned b	by P	Part II. Other significant condition	ns contributing to d	eath but not result	ting in the un	derlying cause giver	n in Part I.		23e. Did tobac	co use contrib	ute to th	ne cause of death?
<u> </u>	n sig									1 🗆 Yes	2 □ No 3	☐ Prob	ably 4 Dinknown
ecords,	w require been sign should b	Completed								24a. Was an	24b. We	ere autor	psy findings available
e Y	sician: The law certificate has b irector, page 2 s	LLC.	-							autopsy performed	d? de	or to con ath?	npletion of cause of
	in: T ificat or, pa	e C	25. Was case referred to medical					0.0 DI	(D		No 1E	Yes	2□ No
	Physician: r this certific ral director,	OB	examiner?	Hospital:	Inpatient 2 E	R/Outpatient				Check onl√one) e 5 🗆 Residenc	6 DOM:	(0	_
0	g Phys er this eral di	E	27. Manner of Death	28a. Date	of Injury 2	8b. Time of	28c. Injury a	at		d. Describe how			"
0	ith. :: After s funer	틽	1 Natural 5 ☐ Pending	9	th, Day Year)	Injury	Work?	os 2.∏N					
DIVISION	Atter r dea octor	iji Liji	3 ☐ Suicide 6 ☐ Could r	ined 286. Place	of Injury - At hom	ne, farm, stre	et, factory, office		28	f. Location (Stree	t and Number	or Rurai	l Route Number,
5	al or	Certification:	4 Homicide determine	build	ing, etc. (Specify)					City or Town, S	State)		
	ospita hours inera y fille		29a. Certifier 1 Certifyin	g Physician: To the	best of my knowl	ledge, death	occurred at the time	, date and	place, an	d due to the caus	e(s) and manr	ner as sta	ated.
	ne Ho ne Fu	edical	(Check only 2 Medical I one)	Examiner: On the b	asis of examination ner stated.	on and/or inv	estigation, in my opin	nion, death	occurred	at the time, date	and place, an	d due to	the cause(s)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	0			29c. License i	number		29d.	Date signed (Month, L	Day, Year)
			1 hours	- Yrul	en MIG	,	70	99	29		11-8	JY-7	2004
			30. Name and address of person	who completed caus			Print)		-/		• •		(
	10		Aaron Snyder, M	D. 9901	Medical	Center	Drive Ro	ckvi	lle.M	farvland	20850		
, ,	Sta		31. Date filed (Month, Day, Year)	32. F	legistrar's Signatu	re	-						
	Registra	ar	MOV O	9 2004	Genera	19	book	21					

State of Maryland / Department of Health and Mental Hyginal [] [

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Betty Jane Atherton November 10:15 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F 578-42-7759 73 Director June 3, 1931 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show Examiner must be notified at 1 Tes 2 No Director Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 death v 5647 Denfield Place United States 21710 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after I □ Yes 2 XNo f Yes, Give Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify: ģ Specify: 3 Widowed 4 Divorced "netural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden, Sumame) it. Pages 1 and 2 should be intriment of Health and Mental of Item 27 is marked o 2 Thomas Somerville, III Betty Bradford 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Atherton Hagen / Daughter 20800 Whites Ferry Road, Poolesville, Maryland 20837 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery 1 ☐ Burial 2 XCremation 3 ☐ Removal from State November 12. Bethesda, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. permit. F Departme Importen any injur Robert A. Pumphrey Funeral Home/ Rockville, 21. Signature of Funeral Service Licensee oßBins 300 West Montgomery Avenue, Rockville, Maryland M01356 Approximate Interval Between Onset 200 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical tract intection Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No 2**□**N6 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Umpatient Certification: To 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD DO61856 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) Lovenzo 9901 Medical Center Drive, Rockville, MD 20850

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 0 9 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyginal [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 8 2004 /Medical Novembor 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KIDGE 5. Social Security Number d. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1**X**M 2□ F 214-16-637 5 Director MAY 38 1919 MARYLAND Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. It e Medical Exertition matter national 10d. Inside City Limits Director 1 ☐ Yes 2 No MO BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 6540 EBENEZER ROAD U.S.A death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ENO If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 'Deportment of Health and Mental Hygiene. Important; If item 27 is marked other than 's may njury or other traumatic event, If a Masones. Elementary/Secondary (0-12) College (1-4or 5+) 12 TOOL MAKER AEROSPACE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GUSTAV ADOLPH AY ADA DIEZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMA 6540 ERENEZER RUAD BALTIMORE MO 21330 LANDIS AY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MOUNT VIEW CEM NOV 11. 2004 SYKESVILLE MO 21. Signature of Furthral Service Licensee 22. Name and Address of Facility MARZYLLO FYNERAL CHAPEL En CFA 6009 HARFORD ROAD BALTIMORE, MD 31314 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Paysician Dementia month 4 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nen Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant af time of death Month Dav Year 5 Other (specify) of Vital Records, P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; After 1 28d. Describe how injury occurred Division 1 Agural 2 Accident 5 Pending death. investigation M 1 TYes 2 □ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 \ Homicide 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1905813 mo o completed cause of death (Item 23a) (Type, Print)

Registrar

Stoner Hue . Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 23b pt 11 25 27 28a-f 2837 11-9-04 vt per meo
State of Maryland Department of Health and Mental Hygiener 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ma v 24^{ay} **Physician** Teresa Y. Blake 2004 10:50A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, July 4 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1958 Maryland 217-74-1739 1 □ M 2**X**□ F 45 Yrs. Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic avant, the Medical Examiner must be notified at Yes 2 No Maryland Anne Arundel Director Annapolis 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ŏ 21401 USA 1604 Clay Hill Rd. or Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th Self Employed Day Care Provider ges 1 and 2 should be filed v t of Health and Mental Hygie If itam 27 le marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy Blake Frances Henson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1604 Clay Hill Rd. Annapolis, Md. 21401 19a. Informant's Name/Relationship (Type, Print) Frances Henson (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ital any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Henson Cemetery 6-1-04 St. Margarets, Md. 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A West St. Annapolis, Md. Javy B. D. ese MOOY 821 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of):

Cocaine use **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit Due to (or as a consequence of): attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Asthma 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes Yes 28a. Pate of Injury (Month, Day Year) in by the funeral Manner of Math 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 2 Accident investigation 5-20-04 1 Yes 2 No unknown unknown Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **home** 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1604 Clay Hill Rd. Annapolis, 4 THomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number

Records, P.O. To the Hospital or Attanding death. within 24 hours a To the Funaral L

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

State

29b. Signature and title of certifier

31. Date filed (Month)

Registrar

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

0

			1 - State Registrar	State of	Marylan	d / Depa <i>Cer</i>	rtment of F	lealth ai Death	nd Mental	Hygie Reg.		3	35571	
	Physici	an	Decedent's Name (First, Middle, Lillian R. Ballard	•					Mon		Day Ye	ar	3. Time of Death 5:23 pM	
	/Medio		4a. Facility Name (If not institution,		er)		4b. City, Town, o	r Location of		4c. County of Death			J. 25pm	
П	Exami	lei		arati			Balta				vo. County of E	Joann		
	Funeral Director		5. Social Security Number 214–88–3392	.Sex 7. 1 ☐ M 2 1 F	Age (In yrs. 41	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		of Birth	nar)	Birthpla Countr aryla	ce (State or Foreign y) Ind	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation		·			100	d. Inside City Limits	
	Mary Ind	tor	MD	NA		Balti:	more						1 X Yes 2 □ No	
	th the	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What	t Countr	y?	
	ath w		1403 Meridene Dr				212:	39			USA			
38	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23a or 28a-f show aumatic event, the Marylod Examined rust by notified at	by Funeral	Narital Status Never Married 2 ₩ Married Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Tes 2 If Yes, Give Year or Date	es? No	lf lf	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 X No	ispanic Origi an, Mexican, Specify:	in? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - A Black, V Specify:	Vhite, et		
2	72 hou	ted	15. Decedent's	Education	ucation 16a. Dece			dent's Usual Occupation kind of work done during most of working				16b. Kind of Business/Industry		
21215-0036	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	Librar:	OO NOT use retired	or working						
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Maryland	d be f) Be	Willie Edwards	51/							den Sumame)			
Z Z	s 1 and 2 should be 1 f Health and Mental I item 27 is marked o other traumatic eve	오	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street		en Edward or Rural Route 1		ty or Town, Stat	te, Zip C	ode)	
	12 E G		Antonio D. Ballar	d/ Husband			Meridene D						,	
altimore,	00-		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3			lace of Disposemetery, crem	sition (Name of natory or other place	ce)	Date	20c	. Location - City	or Tow	n, State	
Ĕ	permit. Pages Department of I Important: If it any injury or o		`4 □Donation 5 □Other (Spe			ar Hill	Cemetery		1-12-04	G.	len Burni	e, MI)	
Bail	Depart Depart Mport Iny in		21. Signature of Juneral Service Lie	censes ///	anda	22.	Name and Addre						o, MD 21217	
58760,	Physician /Medical Examiner but and physician and physician and the prival-transit street but and physician and ph	edical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									pproximate nterval Batween Onset and Death ハドンス(ルブ)		
O. Box		Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year					
Hecords, P The law requires that	w requires that been signed b should be deta	by	Part II. Other significant conditions	ulting in the un	derlying cause give	en in Part I.	23e.		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Monknown					
		Completed							_	Was an autopsy performed Yes 2	?prior death	to comp	y findings available letion of cause of	
Vital	sicien: The certificate irector, pag	Be	25. Was case referred to medical examiner?	Hoenital	spital:					ath (Check only one)				
ō	ing Phy	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	Hospital: 1 Inp. 28a. Date of I (Month,		Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred								
DIVISION	el or Attandi s after death. Il Director: A sd in by the fu	Certification:	3 Suicide 6 Could not determine	ad 288. Place of	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical	one)	Physician: To the be aminer: On the basis and manner	s of examinat stated.	tion and/or inv	estigation, in my of	oinion, death	occurred at the	time, date a	and place, and o	due to th	e cause(s)	
	with To t	Σ	29b. Signature and title of certifier	1. 11			29c. License	number		29d. [Date signed (Mo	onth, Da	y, Year)	
	\/		suphen.	7. Hgs	m-D.		000	426	55	No	VemBe	~	82004	
	9		29b. Signature and title of certifier Supplies 30. Name and address of person wh STEFHEN G: HGL 31. Date filed (Month, Day, Year)	o completed cause of	of death (Item	23a) (Type, F	Print)		RA. 10.	0 - 11	10	. 1		
	- Sta	te	31. Date filed (Month, Day, Year)	32. Regi	istray's Signat	ture ,	4 In	J.	JUGITU		BOIT	1/1	Ore	
	Registr	ar	NOVO	9 2004	Dener	-	, japo							

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		edent's Nam	e (First, Middl	e, Last)							2. Date	of Death	Day	Year	3. Time of Death	
an cal	1		Alice			Lee			Blac	kley			ember		2004	2:508	
ner	4a. Facility Name (If not institution, give street and number) Stella Maris Mercy								4b. City, Town, or Location of Death					4c. County of Death			
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으		Ralph				T. Meade				Jeanette				Pollard			
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add Verndetta Williams Daughter 4790 Si																
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State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

NOV 0 9 2004

30. Name and address of person who com ded cause of death (Item 23a) (Type, Print)

David Risebarg 301 5T

31. Date filed (Month, Day, Year) 32 Registrar's Signature

Baldinore

50515

nd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 35573 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year niel 6500AM November YOUS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sallimore C If Under 1 Year | If Under 24 Hrs. HOSPITA NA Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2/□ F 32 Yrs Director 6-24-72 221-52-2433 Delaware Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other treumatic event. It a Modical Examiner man be notified at once. 10a, State 10b. County 10c. City. Town or Location 10d. fnside City Limits Md. NA Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 2812 E. Chase Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Food Chain 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be L. ပ Charles Sandra Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1818 N. Collington Ave., Baltimore, Md. Ruth Hamilton Grandmother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-9-04 Union Hill Cem. Kenneth Square, Pa. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 区 I a Warner March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician neumonia 2 weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) nding physicien use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) 4☐ Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ionyopath 24a. Was an has 2 0 1 Yes within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, To the Hospitel or Attanding Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Imp, tient Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-2000 11/03 2004 m.D 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sangee Sheh Juns Hopkins GOS N. wife 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 5, perFH Go40, 2/4/05 State of Maryland / Department of Health and Mental Hygiens amend item# 35574 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** Lutt Month Jilliam Facility Name (If not institution, give street end number) 2004 /Medical 4b. City, Town, or Locetion of Death Examiner 4c. County of Death (enter Rasedale Balto If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year 4/30/1928 **Funeral** Birthplace (State or Foreign Country) Days 11℃M 2□ F Yrs. Director 76 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. N/A BALTIMORE 1 No Yes 2 No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6213 FAIR OAKS AVE. 21214 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ⊠Yes 2 □ No If Yes. Give Completed by 1 ☐ Yes 2 ☑ No Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EMMA MICHELE HERBERT CHILCUTT 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
6213 FAIR OAKS AVE., BALTIMORE, MARYLAND 21214 19a. Informant's Name/Relationship (Type, Print) ROBERT ROYAL/SON 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY 11/10/04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) gead Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown ballbes þ Completed 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to (bula De are completion of cause of deeth? levone Leval 1 Tes 2 HNO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 1 No 28e. Date of Injury (Month, Day Year) 27. Manner-of Death 28d. Describe how injury occurred Injury at Work? 1. Natural 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. this certificate funeral director, or Attending death. after death Director: / the within 24 hours after de To the Funeral Directo completely filled in by tt

Records, P.O. Box 68760, A law requires that the death certificate be executed

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

7 is marked other than "netural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notfilled at

Hygiene.

and Mental Hygie Is marked other

Department of Health a Important: If item 27 Is any Injury or other trainonce.

Physician /Medical

Examiner

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State Registrar

31. Date filed (Month, Day, Year) NOV 1 0 2004

MICHAEL SCHWARTZ M.D.

Milleage

32. Registrar's Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

D 19667

7310 RITCHIE HIWY, GLEN BURNIE, MARYLAND

11-09-2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 26 01: 35575

			For State	Sta	ite of Ma	aryland /	-	rtment of He tificate of D		^	Reg. No.		33313
			Registrar Decedent's Name (First, Middle)	fle, Last)						2. Date of De		Year	3. Time of Death
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	Examin		4a. Facility Name (If not instituti			_		4b. City, Town, or		1	4c. County	y of Death	
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	Funeral Director		5. Social Security Number 215-02-5672 Usual Residence of Decedent	6. Sex 1 ☑ M 2		22	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Oct 30	ly, Year)), 1982	Соц	ntry) Maryland
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	th wil	al	725 Linnard Street						21229			U.S.A	
36	be filed within 72 hours after death with the Maryland all Hygiene. Id Hygiene. of terms 23s or 28s-f show other than "natural", or items 23s or 28s-f show event, the Madical Examinal must be notified a	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	urried 1 [as Decedent med Forces? Yes 2 (2) Yes, Give ear or Dates:			Vas Decedent of His Yes, specify Cubar ☐ Yes 2 ☐ No	spanic Origin? (S) n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specil	ck, White,	can Indian, etc. Black
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	other tr		20a. Method of Disposition	101		20b. Place	of Dispo	sition (Name of patery or other place		Date	20c. Location	- City or T	own, State
OL.	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		al from State	came		r Hill Cemete		11/15/04	Balti	more, N	/laryland
Baltimore,	permit. Pages Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service	1.6				. Name and Addres		ral Home P	.A.		
			23a. Part1. Enter the disease,	or complication	s that caused	d the death. D	o not enti	1300 Euter the mode of dying	taw Place E , such as cardiad	saltimore, M or respiratory a	D 2121/ rrest,		Approximate Interval Between
	Physician		shock, or heart failure. Li Immediate Cause (Final	st only one cau	Gunsh	1	in	of c	hact				Onset and Death
	/Medical Examiner		disease or condition resulting in death)	(a		a consequence		, ,,	7,1031				
		er	Sequentially list conditions, if any, leading to immediate	b	Due to (or as	a consequenc	ce of):						
	outed Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 c									
0	icate be executed physician and s the burial-transit		resulting in death) Last		Due to (or as	a consequenc	ce of):						
68760,	hysicithe bu	edicai		d									
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 [4[Live birth	of pregnancy 2 Petal dea t time of death		Ectopic pregnancy Other (specify)				ate of deliv	ery Day Year
P.0	that the		Part II. Other significant condi	tions contribut	ing to death b	out not resulting	a in the u	nderlying cause give	n in Part I.	23e. Did 1	obacco use con	tribute to t	the cause of death?
ds,	uires t signe Id be o	d by						, ,		1 🗆	Yes 2 No	3 □ Pro	bably 4 □Unknown
Vital Records	w regulations	Completed								24a. Was	an 24b.	Were auto	opsy findings available
Re	The lavate has	ошо									psy prmed? 2 \sum No	prior to co death? 1 X Yes	ompletion of cause of 2 ☐ No
tal		0	25. Was case referred to media	cal					26. Place of Dea	-1		7	
Į.	99 (0)	To B	examiner? 1X Yes 2 □ No	Hospita	al: 1 🔀 npati	ent 2 ER/	Outpatien	t 3□ DOA Othe	1. 4 ☐ Nursing H	lome 5 ☐ Resi	dence 6 □Oti	her (Speci	fy)
n of	ding Phy h. After this funeral c		27. Manner of Death 1 □Natural 5 □ Pen		a. Date of Inju (Month, Da	ury 28t	b. Time of Injury	28c. Injury Work	? ,	1171	how injury occur	rred	<u>.</u>
Sio	death. ctor: A y the fu	cati		stigation	11-7-04		0110		res 2 No	Subject	Street and Num	5 WO	al Route Number,
Division	ai or Attend s after death	Certification:		rmined 28	building, e	tc. (Specify)	Stre	eet, factory, office		City or To	wn, State) 72	5 Li	nnard street
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier 1 Certification Check only cone)	al Examiner: C	: To the best on the basis on anner st	of examination	dge, death and/or in	occurred at the time restigation, in my op-	e, date and place sinion, death occu	, and due to the irred at the time,	cause(s) and m date and place,	anner as s and due t	stated. to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certi					29c. License			29d. Date signe		
)			I him K	i. m	Q,				CME		Novemb	er 8,	2004
	h		30. Name and address of person	-	ed cause of				Dal+ima	Ma-	o backer	1201	
	7)		21 Date filed (Month Day Ye	m. D	32 Dogict			n Street,	раттик	ле, Mar	утана 2	1201	
	Sta Registi		31. Date filed (Month, Day, Ye.		32. Regist	rar's Signature	4	1 ,					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35576 State of Maryland / Department of Health and Mental Hygie Pe 1 1 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:35 A M NOV. 2004 **JACOUILIN** CRAIG 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL HERITAGE HARBOR HEALTH & REHAB. ANNAPOLIS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 201-14-0395 **Funeral** 1 ☐ M 2 🗶 F 06/10/1925 Director PA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 14 Bace - American Indian Black, White, etc. WHITE Specify: 16b. Kind of Business/Industry ACADEMIC 18. Mother's Name (First, Middle, Maiden Sumame) RABINOWITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 S. CHERRY GROVE AVENUE ANNAPOLIS, MD 21401 BETH SHALOM CEMETERY 11/09/2004 PITTSBURGH, PA. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 18900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Meny years

Division of Vital Records, Hospital or Attending Physician: After t Director:

28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

28d. Describe how injury occurred

29b. Signature and title of certifier

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

MD.

D 40519

1 ☐ Yes 2 ☐ No

11-6-04

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d Date of delivery

Month

Many

Day

3 Probably 4 ⊠Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

yeurs

Mony Genry

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Nussires, 1401 Madison Park 21061, Gilan Burnie, Maryland. 31. Date filed (Month, Day, Year)

State Registrar

Certification:

Medical

NOV 1 0 2004

5 Pending investigation

6 Could not be determined



within 24 hours a To the Funerei E

the

Stamos Courpas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 7184State of Maryland / Department of Health and Mental Hygiere 1 dl Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Stamos Alexis Courpas November 2004 11:06 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Green Ridge Forest @ Sugar bottom Rd Little Orleans
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 15, Birthplace (State or Foreign
Country) Age (In yrs. last birthday) 5. Social Security Number . 1969 Greece **Funeral** 1**⊠**M 2□ F 220-21-9538 35 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State r than "naturel", or Items 23e or 28a-f show the Magical Examiner count be notified at 1 ☐ Yes 2 No Director Fairfax Fairfax Virginia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 22033 12904 Starters Lane filed within 72 hours after death Funera 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) <u>Tellabs Inc</u> <u>Sr. Hardware Design Engineer</u> 5+ Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental <u>Sevasti Margaronis</u> 2 Michael Courpas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tre Fairfax, Virginia 22033 12904 Starters Lane Mrs. Maria Courpas/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 11/12/04 Cub Hill, Maryland Demetrios 22. Name and Address of Facility 21. Signature of Funeral Service License Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gunshot wound of **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9□ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 N Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No

After death.

Be Certification:

Hospitel or Attending Physicien: after death filled in by the within 24 hours a To the Funerel D

State Registrar 29b. Signature and title of certifier

NOV 0 9 2004

25. Was case referred to medical

1 ¥ Yes 2 □ No

examiner'

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Momicide

his

mid

28a. Date of Injury (Month, Day Year)

11-6-04

and manner stated

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

10:00 A M

Forest

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

OCME

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Yes 2 No

26. Place of Death (Check only one)

111 Penn Street, Baltimore, Maryland 21201

Other: 4 Nursing Home 5 Residence 6 Hother (Specify) SCENE

28d. Describe how injury occurred

subject was shot

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Green Ridge Forest

@ Sugar botton Rd Little Orleans

November 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LI LING 31. Date filed (Month, Day, Year)

investigation

6 Could not be determined

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygier 1 - State Amend Items 23a, PtI, PtII, 25, 27, 28a-f per MB, 6837, 11/10/04(th) 35578 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MELVIN CAVALIER Angust 24 1:40 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Sinai Hospital of Balt!more City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 □ F Days 219-05-1468 82 Yrs. MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, I'lla Nedical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1. Marital Status

1. Merital Status

1. Never Married

2. Married

3. Widowed 4. Divorced

12. Was Decedent Ever in U.S. Amped Forces?

1. Yes 2. No If Yes, Give Year or Dates: Funeral 21208

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No à Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BUYER MEN'S CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I SAMUEL CAVALIER KATZOFF MOLLIE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trau 10 STONEHENGE CIR., APT. 8 PHYLLIS CAVALIER (WIFE) BALTO., MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) SHAAREI ZION 8/27/04 ROSEDALE, MD 21. Signature of Funeral Service Cen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracerebral hemorrhage **Physician** Un bernon resulting in death) /Medical Due to (or as a consequence of) Examiner nathrown Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Examiner (brias a consecuence of) The law requires that the death certificate be executed and that initiated events resulting in death) Last physician as Due to (or as a consequence of): Box 68760 CERTIFICATION APPROVED BY MEDICA Physiclan/Medlcal attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9☐ Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by Warfarin therapy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ibvillation performed? of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one) examiner's Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1

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Y Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Accident 5 Pending thours after death.

uneral Director: After the function of th investigation 1 ☐ Yes 2 ☐ No Unknown Unknown Unknown 6X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown Unknown within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES - 460 August 24, 2004 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Hospital of Bultimore MD John 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

NOV 0 9 2004

Known

Carl D. Deise Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department / 04 - 7154**AKG** Decedent's Name (First, Middle, Last)
Carl D. Deise Jr. 2. Date of Death 3. Time of Death Year **Physician** Carl David November 5. 2004 7:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5517 Harford Road N/A Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 X M 2 ☐ F Months Yrs. Director 213-60-7493 1952 Maryland Nov. Usual Residence of Decedent or 28e-f show 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 □ No Director Maryland N/A Baltimore with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or then "neturel", or Items 23e or the Medical Examiner must be 5517 Harford Completed by Funeral Road 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ▼ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Lounge Bartender marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) in and 2 should be fill Health and Mental Health and Mental Hem 27 Is marked oth Be Carl DAvid Deise, Sr. 2 Nancy Lee Knapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Nancy Browneller/ Mother 1651 E. Belvedere Ave. Baltimore MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ò 1 Burial 2XX remation 3 Removal from State ≒ 5 permit. Page Department of Importent: If eny injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Balto./Wash. Crematory 11/08/04 Laurel MD 21. Signature of Fune I Service Liversee 22. Name and Address of Facility Miller-Dippel Funeral Home, 6415 Belair Road Baltimore 23a. Part1. Enter the disease or contact or heart failure. List only iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause on each line. Approximate Interval Between Onset and Death shock, or heart failured Immediate Cause (Final disease or condition resulting in death) Physician Complications of Chronic Alcoholism /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) Ó ٥ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Pe 1 Yes 2 No 3 Probably 4 NUnknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? death? 1 Yes 2 \(\text{No} 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) at SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 1XXYes 2 □ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 X Natural
2 Accider Injury 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation death after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 \ Homicide filled in 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 O.C.M.E. November 5, 2004 30. Name and address of person who completed cause of death (from 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 degistrar's Signature 31. Date filed (Month, State

Registrar

1 0 2004

		For State Registrar	State o	f Marylan		artment of H				ene .200!	₊ 355	80
		Decedent's Name (First, Middle)	Last)				-		Date of Death)	3. Time of	
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Exami		4a. Facility Name (If not institution,	give street and nu			4b. City, Town, or	Location of			4c. County of		
		Wilson Health	Care			Gain	thers	burg		Monte	gomery	
Funeral			6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		24 Hrs. 8. D	Date of Birth Month, Day,	9	Birthplace (State of Country)	r Foreign
Director		208-28-7155	1 ☐ M 2 反 F	99	Yrs.	World S Days	, iodio	Ma	rch 4,	1905	Öhio	
pur *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	eation					10d. Inside Cit	n/ Limite
lanyli I sho	ō										1x Yes	
the A	Director	Maryland Montg	gomery		Gait	hersburg 10f. Zip Code			10	g. Citizen of Wha		
with sa or						,	7 - 7					
leath	era	301 Russell Av		edent Ever in U	.S. 13.	Was Decedent of H		gin? (Specify \		United S	tates American Indian,	
Destrictions, Mary grants and 2 12 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any highly or other treumstic event, the Marical Exercice must be notified at 9008.	Funeral	1 Never Married 2 Marrie	Armed Fo	rces? 2t☑No		f Yes, specify Cuba	in, Mexican	n, Puerto Ricar	n, etc.)		White, etc.	
al', o	by	3X Widowed 4 ☐ Divorced	If Yes, Gir Year or D	ve ates:		1 ☐ Yes 2X No	Specify:			Specify:	White	
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ed w ygier t,	Ö		<u> </u>			Secret					s Office	
be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, L					18. Mothe			aiden Sumame)		
al yla	ို	Chauncey Boyd			-			Ann Jo				
VICE 12 st h and 7 ls r treur		19a. Informant's Name/Relationsh		la 40 a 40		ng Address (Street a						
T, IV 1 and Health em 27 ther ti	1	Leatrice Ann Hug	gnes/ Daug	20h E	Place of Disno	sition (Name of		Lane, S		Sprin, Oc. Location · Cit	MD 20906	
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partification Pages Department of Moortant: If it in y injury or one.		` 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service Ł		Mem				2004	A D	Camp Hi		
permit. Departn Importe any inje		1 Caic	Ex	MO1386	Ro Ro	ckville, ckville,	Inc. Maryl	300 WE Land 20	850-28	imphrey it omery 305	Funeral H Avenue,	ome
		23a. Part1. Enter the disease, or c shock, or heart failure. List of	complications that only one cause on e	aused the deat	h. Do not ent	er the mode of dying	g, such as	cardiac or resp	piratory arres	st,	Approximate Interval Bety	veen
Physician		Immediate Cause (Final disease or condition	a (nue al	nonia						Onset and D	eath
/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):							7 -
	<u>.</u>	Sequentially list conditions,	b. Due to	(or as a conseq	uence of):							
red red	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dasacs of Figure) that initiated events	Due to	(or as a correct	derice or).							
xecu n and al-tra	xar	that initiated events resulting in death) Last	c	(or as a conseq	uence of):							-
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E											
ificate g phy is the	edic		u									
iries that the death certifications by the attending good by the attending good be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna		T-+i				23d. Date of	f deliv <i>er</i> y	
deatl deatl e atte	icia	in the past 12 months?	4☐ Pregr	oirth 2 ☐ Feta nant at time of d		Ectopic pregnancy Other (specify)				Month	Day Y	ear
by the	hys	9 🗌 Unknown	9□ Unkn	own								
gned gned	by F	Part II. Other significant condition		eath but not res	ulting in the u	nderlying cause give	en in Part I.	. 2	23e. Did toba	icco use contribu	te to the cause of de	ath?
w require	ted	demo	Ulta -						1 🗌 Yes	2 □ No 3 □	Probably 4 🗹 U	nknown
law ra as be 2 sh	Completed							2	24a. Was an autopsy	24b. Wer	e autopsy findings a r to completion of ca	vailable
The The ate h	Corr							1	performe	ed? deat	h? Yes 2□ No	
VII.di nec sicien: The law certificate has b lirector, page 2 s	Be (25. Was case referred to medical examiner?						of Death (Che	eck only one)		
hysic this call dire	2	1 ☐ Yes 2 Z No		npatient 2			4 anul	rsing Home	5 🗌 Residen	ce 6 Other (Specify)	
ding P	on:	27. Manuer of Death 1 Natural 5 Pending		of Injury th, Day Year)	28b. Time of Injury	Work			Describe how	v injury occurred		
ttend death death tor:)	cat	2 Accident investigation inves	ot be	of lainer At he			Yes 2□N		anation (Ctus		-0-10-11-1	
or A after a Direction by	Certification:	4 Homicide determin	ned 200. Place buildi	ng, etc. (Specify	y)	eet, factory, office			City or Town,		r Rural Route Numb	er,
prited ours perel filled		29a. Certifier 1 Certifying	Physician: To the	best of my kno	wiedne death	occurred at the tim	a data and	d place, and di	up to the cau	sco(e) and manne	ur as stated	4
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical E	xaminer; On the b	asis of examina ner stated.	tion and/or in	estigation, in my op	pinion, deat	th occurred at	the time, dat	e and place, and	due to the cause(s)	
To t To t	Σ	29b. Signature and title of certifier	$-\bigcap$	1		29c. License	number	10		Date signed (M	fonth, Day, Year)	0
			10	Jum		0.	001	40		400	1 200	4
B		30. Name and address of person w	Dolinsk	e of death (Item	1 23a) (Type,	Print) Russell	Ave	, 6 a	ithersb	urg 1	nd	
St	ate	31. Date filed (Month, Day, Year)	32. P	edistrar's Signa		Local		-		7		
Regist	rar	e o vem	2004	Genera	· 19	Look	2/					

State of Maryland / Department of Health and Mental Hygier 0 0 14 35581 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LISS AM ANTHONY L. + LOWERS Nov 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MEDICAL CENTER 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** ŊĴ 220-78-3739 Director Usual Residence of Decedent 10d. tnside City Limits 10b. County 10c. City, Town or Location rthan "natural", or Iteme 23e or 28e-f show the Medical Examiner must be notified at X□Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21205 2728 E. Monument St. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 | Yes 2 | No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Specify Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) 12th College (1-4or 5+) Construction Home Emprovment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Wilbert Flowers Shirley Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Morrison (mother) 2079 Woodbou 20a. Method of Disposition (Name of cemetery, crematory or other place) 2079 Woodbourne Balto. Md. permit. Pages 1
Department of H
Importent: If itel
any Injury or ott 11-11-04 Dundalk, MD * 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart 22. Name and Address of Facility Wesley Chavis Jr. F.H 21. Signature of Funerat Service Licen 2007 Eastern Ave. Balto 23a. Part. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Balto. MD 21231 Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician Metastatic concer, unknown type months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine ned by the attending physicien and detached for use as the burial-transit equires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospitel or Attending Phye within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier P16561 NOVEMBER 6, 2004 ss of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND CINA, MD - 22 S. GREENE ST., 31. Date filed (Month, Day, Year) 32. Registrar's Signature Staté NOV 1 0 2004 > Registrar

B.K.S CHASITY FLANAGAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/Medi	ian	Decedent's Name (First, Middle, Last) CHASITY FLANAGAN		2. Date of Dea Month	Day Year	3. Time of Death
	ical	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	NOV.	4, 2004	0924 A A
Exami	ier	BOWIE HEATH CENTER	BOWIE		4c. County of Death PRINCE G	EORGES
Funeral Director		5. Social Security Number 172-80-0709 G. Sex 1 M XX F	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 7 / 4 / 1 9 8	9. Birthp	lace (State or Foreig XIDA
yland now		10a. State 10b. County 10c. City, Town or Lo	ocation		1	0d. Inside City Limit
death with the Maryland ms 23e or 28a-f ehow must be notified at	ctor	MD PRINCE GEORGES BOWIE				1 🗆 Yes 🗶 N
ith th	Director	10e. Street and Number	10f. Zip Code	11	log. Citizen of What Coun	try?
s 23e	ral	2931 TALLOW LANE	21075		USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if item 27 is marked other then. Inspiritury or other treumetic event, the Medical Eventrand must be notified at ance. Once.	t by Funeral	1.A.MNever Married 2 □ Married 1 □ Yes 2.A.DNo	Was Decedent of Hispanic Origin? (S _i f Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 Honor Specify:	pecify Yes or No- Pican, etc.)	14. Race - Americ Black, White, Specify: WHIT	etc.
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d be filed a antal Hygie ted other c event, to	Be	17. Father's Name (First, Middle, Last) THOMAS FLANAGAN	18. Mother's Nam	e (First, Middle, i	Maiden Sumame)	· · · · · · · · · · · · · · · · · · ·
should nd Me mark	10		ng Address (Street and Number or Ru			Code)
and 2 alth a 127 ls			EAST CUMBERLAND S			0000)
of He of He fitem		20a. Method of Disposition XXBurial 2 □ Cremation 3XX Removal from State 20b. Place of Disposition cemetery, crem	sition (Name of natory or other place)	Date	20c. Location - City or To	wn, State
. Pag tment tent: I		`4 □ Donation 5 □ Other (Specify) PERRY HE	IGHTS CEM. 11/	10/04	MARYSVILLE,	PA
permit Depart Impor eny in		The Care of the Ca			MORTUARY SUE	
462 0 0		KELLY GRÉGORÝ FINK #M01148 426 23a. Part I. Ente the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	6 CRAIN HIGHWAY S	., GLEN	BURNIE, MD 2	1061 Approximate
/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.				Onset and Death
artificate be executed ing physician and a as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)			Day Year
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		-	For State Registrar		State of Ma	arylan				lealth and Death	Mental Hy	giene Reg. No	200	4	-3558	2
	Physici /Medic	an	1. Decedent's Name (First, Donald	Middle, Last	F	OVY	est				2. Date of De Month	1 Day	5 th 20		3. Time of Death 21:25	VI
	Examin Funeral Director	er	4e. Facility Name (If not inst Howard C 5. Social Security Number 165–24–8415	Ounil 6. Se	y Gener		HOSP - last birthday Yrs.		ar 1 Year	Location of Dea Column If Under 24 Hrs Hours Min	BLA 8. Dete of Bi (Month, D	rth ay, Year)		VA inthple Countr	RD ce (State or Foreign) NSYLVANI	
	land bw		Usuat Residence of Deceder 10a. State 10b. C			10c. Cit	y, Town or L	ocation						10	d. Inside City Limit	s
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	with th	Director	10e. Street and Number 222 MARGANZA	S					ip Code 20724			_	izen of What	Count	y?	
036	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or items 23a or 28a-f show event, the Modical Examinar? and be notified.	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 Div	Married	12. Was Decedent Amed Forces? 1 X Yes 2 1 N Yes, Give Year or Dates:		0-		edent of H	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or N to Rican, etc.)		S.A. 14. Race - An Black, Wh	nite, e	tc.	
21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Dec (Specify only) Elementary/Secondary (0 12th		ication le <i>completed)</i> Coll ege (1-4or 5	+)	(Giv life.	edent's Us e <i>kind</i> of w DO NOT LYST	ork done	during most of wo	orking	16b. K	ind of Busines		istry	
	il Hygi other	Be	17. Father's Name (First, M LLOYD F	iddle, Last)	n		AIVA	T101			me (First, Middle		Surname)			
Maryland	should be ind Mental is marked or imatic eve	ပ	19a. Informant's Name/Rel				19b. Mai	ling Addres	s (Street	FKIED and Number or R	A CHRIST		or Town, State	, Zip (Code)	_
	and 2 salth ar n 27 is		WAYNE E. F	ORREST	T/SON		112	CARM	ICHA	EL CT. Q	UEENSTO					
Baltimore,	permit, Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic ev once.		20a. Method ol Disposition 1 □ Buriel 2 ☑ Crem. 1 □ Donation 5 □ Ot	ner (Specify)		0		smatory or SHC	REMA	FORY 11-		LAUR	EL, MD			
Ball	Depart Import any in		21. Signature of Funeral Se	vice Licens	wart					ss of Facility FL SPRING						
8760,	Physician /Medical Examiner sthe parial-transit sthe parial-transit	dical Examiner	23a. Part1. Enter the diseashock, or hear fellure shock, or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ſ	Due to (or as Due to (or as Due to (or as Due to (or as	a consequence	uence of): uence of):	-S.	hocilwa	g, such as cardia		arrest,			Approximate Interval Between Onset and Death	
.O. Box 6	death certif e attending id for use as	Completed by Physiclan/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 Yes 2 No 9 Unknown	uru [23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	death 3	□Ectopic □ Other (a		,			23d. Date of d Month		/ Day Year	
<u>α</u>	The law requires that the ate has been signed by th page 2 should be detache	ed by Ph	Part II. Other significant co		ntributing to death b		eulting in the			en in Part I.			use contribute		cause of death?	m
Division of Vital Records,		Complete	adrena	l's	nsuff	eu	en	1			24a. Was auto perf 1 Yes		prior to	o com ?	sy findings availab pletion of cause of	le
Vita	sician certifi rector	Be	25. Was case referred to mexaminer?	-	Hospital:	- 1 O -	ER/Outpatio	ent 3 🗆 🗈	Oth Oth	0.0	eath (Check only Home 5 Res		6 Dothar (Co			
ion of	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	atlon; To	27. Manner of Death 1 Natural 5 □ I	Pending nvestigation	28a. Date of Inju (Month, Da	ry	28b. Time Injury		28c. Injur Wor	4 🗀 iadising	28d. Describe			эвспу)		
Divis	al or Atte safter des f Directo d in by th	Certification;		Could not be determined	28e. Place of Inj building, et	ury - At h	ome, larm, s	treet, facto	ory, office		281. Location City or To			Rural	Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier Concept (Check only one)	rtifying Phy dicel Exam	rsician: To the best iner: On the basis of and manner sta	examina	owledge, dea	ath occurre investigation	d at the tir	ne, date and place pinion, death occ	e, and due to the curred at the time	cause(s) and manner d place, and d	as sta	ted. he cause(s)	
)	To th within To th compl	Me	29b. Signature and title of	pertifier _	-Mz			2	9c. Licens	e number		29d. Da	te signed (Mo	nth, D	ey, Year)	4
	1,+1		30. Name and address of p		ompleted cause of d	eath (Iter	n 23a) (Type	a. Print)	Be	ll las	u Cl	ark	sulle	. Y.	96 Th 200	9
	Sta Registi		31. Date filed (Month, Day,	9 200	32. Registr			So	aks	/						

State of Maryland / Department of Health and Mental Hygiend 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 12:50 P M James J. Fraher November 7, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Baltimore Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 31, 1 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1X M 2□ F Director 054-26-4832 75 New York Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 77 is marked other than "natural", or items 23a or 28a-1 shov traumatic event. The Medical Examinar must be notified at 1 Yes 2 X Yo Director Towson Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 540 Allegheny Avenue 21204 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give 1,954-1959 Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ould be filed within 72 hours after of Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X**XNo Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event. The Medie 2006. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Aerospace Industry Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0'Brien Fraher Margaret P J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, 540 Allegheny Avenue Maryland Patricia Fraher Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Hilltop Service Corp. 11-9-2004 Towson, Maryland 21. Signatur 22. Name and Address of Facility or Furieral Service Ligensee Ruck Towson Funeral Home, Towson, Maryland 21204 1050 York Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one place on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** yocard Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Box 68760 Physician/Medicai detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) O 9 Unknown certificate has been signed by ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à pe 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an page 2 Yes 2 🗆 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Certification: To 6/ Other (Specify) this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 □ Yes 2 □ No death. investigation s after death. 2 Accident pletely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide vithin 24 hours a Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c_License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1601 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 10 1 1

Physic		1. Decedent's Name (First, Middle, Last Geraldine	Lucille	Fea	nrs		2. Date of D Month Octo	Day	8, 2004	3. Time of De
/Medi Exami		4a. Facility Name (If not institution, give				or Location of Deat			ounty of Death	7.10
		101 S. Carlisl	e Drive			Spring		М	ontgome	ery
Funeral		5. Social Security Number 6. Se	וא מסב	yrs. last birthday) O Yrs.	If Under 1 Year Months Days		(Month, D	ay, Year)	9. Birth	place (State or Fintry)
Director		439-16-1312 Usual Residence of Decedent	A 8	9 Yrs.			Oct. 29	9, 191	4 Mlss	sissippi
Mot		10a. State 10b. County	100	. City, Town or Lo	ocation					10d. Inside City L
8-f s	ctor	MD Montgome	ery S	ilver Sp	ring					1 □ Yes 2
or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?
s 23a	rai	101 Carlisle Driv		- 110	20904			USA		
ltem Iter	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🕅 No	in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or N o Rican, etc.)	0- 14.	Race - Ameri Black, White,	
el, or	þ	3 Midowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		S	pecify:	Black
naturel', or Items 23a or 28a-f show	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup	pation during most of wor	tina	16b. Kind	of Business/Ir	
then "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	daning most or wor	King			
Hygiene. other then ent, the M		12 17. Father's Name (First, Middle, Last)		Sean	stress	40 34-4-4-31-4	(5: 14:1-4		anufact	uring
ed of	Be	Shelly Weary				18. Mother's Nar	ne <i>(First, Middie</i> nine Pat		,	
f Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23s or 28a-f show other traumatic event, It a Michael Exercities investive incities at	2	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (Street	and Number or Ru				o Code)
27 Is r trau		Margeau Gilbert			4 Hopefi		Silver			
Department of Health a Importent: If item 27 Is any injury or other trat once.		20a. Method of Disposition	120	b. Place of Dispo			Date		tion - City or T	
nt: If ry or		1 ☐ Burial 2 X Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		itan Cre		10/29/04	Ale	xandria	, VA
Departm Importe any inju		21. Signature of Funeral Service Licens	96	22	2. Name and Addre	ess of Facility				•
. A E 6		Xuen is	000dQ1		3006 Wes	ciety, In t Burbank	nc. Blvd.	Burba	nk. CA	91505
nysician Medical Kaminer the parial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the conditi	ecubiti sequence of): Syndrome						
as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	dd. 23c. If yes, outcome of pre 1 □Live birth 2 □ f	etal death 3	Ectopic pregnanc	y		230	. Date of delive	ery Day Ye
by the a tached f	ysic	1 ☐ Yes 2 ☐ X No 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown	of death 5	Other (specify) _				14101111	Day 100
n signed by uld be detac	by	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		tobacco use		he cause of dea
as been si 2 should	Completed	COPD					24a. Was	an 2	4b. Were auto	psy findings av
icate ha	Ho						auto perfe	psy ormed? 2 XNo	death?	mpletion of cau 2□No
certifica rector, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea				
this ce al dire	2	1 ☐ Yes 2 🛣No		2 ER/Outpatier		4 Nursing H	ome 5X Resi			y)
After Auner	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wor		28d. Describe	how injury o	ccurred	
deal ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Abuilding, etc. (Sp	At home, farm, str ecify)		Yes 2 □No	28f. Location (City or To	Street and N wn, State)	umber or Rura	l Route Number
erel filled	edical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death	n occurred at the tire vestigation, in my o	me, date and place pinion, death occu	and due to the red at the time,	cause(s) and date and pla	d manner as since, and due to	tated. o the cause(s)
n 24 hc	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Date s	gned (Month,	Day, Year)
within 24 ho To the Fun completely					D/700			A . I		4
within 24 hours after To the Funerel Dire completely filled in b		Mo S	Mo		D4783	38		11-	1-0	4

Physic /Med Exam

Funera Director

HA	RDT For 1 State		State of	Maryland /	Depa	delible Ink. artment of H	ealth a		lental Hy	gie	<u>R</u> e() () [3558	6
	Ragistrar AM			R INF G8.	S/CFI	<i>†ifi92916401</i> 51	1cairi		2. Date of De	Rag.	No.		3. Time of D) eath
	Decedent's Name	e (First, Middle, La	St)						Month		Day '	Year	3. Tame of L	Jeani
ian cal	Dariman	d Steph	hen G	ebhardt.	Jr.				NOV.	8			0713	A M
ner	4- Fasilia Noma //			ber)		4b. City, Town, or	Location of	f Death			4c. County o	f Death		
iei		OODLEA A'	VENUE			BALTIMO	RE CI	TY			٨	I/A		
Т	5. Social Security N			. Age (In yrs. last	birthday)	If Under 1 Year	If Under 2		8. Date of Bi	th V	205)	9. Birthp	lace (State or	Foreig
	212-48-66	635 ¹	M 2□ F	57	Yrs.	Months Days	Hours	Min.	August	28	,1947	Cour	Marylan	ıd
7	Usual Residence of	Decedent												
	10a. State	10b. County		10c. City, To	own or Lo	cation						1	0d. Inside City	/ Limits
ctor	Maryland	N/	A			Baltimor	.e						1X Yes	2 🗆 No
ě	10e. Street and Nur	mber				10f. Zip Code				10g.	Citizen of Wi	hat Cour	ntry?	

Α.

White

Approximate Interval Between Onset and Death

AT SCENE

28f. Location (Street and Number or Rural Route Number, City or Town, State) 4714 Wccdle.a AVE

29d. Date signed (Month, Day, Year) NOV • 8, 2004

Baltimore mo

Ճ Funeral Be Completed by

filed within 72 hours after death with the Maryland an "natural", or Items 23a or 28a-f show Medical Examiner must be nutified at ä permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other traumatic evant, 9068.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

attending physician and for use as the burial-transit death certificate be executed After this To the Hospital or Attending Pl within 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

Examine Physiclan/Medical by Completed Be Certification; Medical

6 ☐ Could not be

LI

WOV 1 0 2004

3 Suicide 4 - Homicide

(Check only one)

29b. Signature and title of certifier

LIN4

31. Date filed (Month, Day, Year)

29a. Certifier

4714 Woodlea Avenue 21206 S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 2 Years Claims Specialist Leasing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Gebhardt, Sr. Thelma Coster 19a. Informant's Name/Relationship (*Type, Print*)

JANES

Linda Jones (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9650 Gudel Drive, Ellicott City, Maryland 21042
e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem'l Gardens 11/12/2004 Bel Air, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Si Funeral Service Licensee 9705 Belair Rd., Baltimore, Maryland 21236 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Head and work Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 风 Yes 2 □ No 24a. Was an autopsy performed? 1X Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending investigation Subject fell Found 11-8-04 Found 7:10 AM 1 ☐ Yes 2 No 2 Accident

DHMH 17 Rev 1/2001

State

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

m.D

32. Registrar's Signature

1 Poplaramen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

At

home

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

oaks

29c. License number

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Gibson Staples 12:26 AM Laura 2004 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 215-22-5754 79 SĆ Usual Residence of Dece 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits No 2 □ No Director MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5610 Gwynndale 21217 U.S.A. Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XIXNo Specify: Specify: <u>ک</u> 3√Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker House 3rd grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Cobit Lee Magdeline Lee Hutchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Marcus-Daughter 4637 Rokeby Road, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 11/12/04 Randallstown, Md 21. Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athensilaritie comproversion Due to (or as a consequence of): Due to (or as a consequence of): Matica

Physician /Medical Examiner

attending physician and for use as the burial-transit

the

been signed by

has

To the Hospital or Attanding Physician: 1 within 24 hours after death. To the Funeral Director: After this certificat

Director: After that in by the funeral

completely

detached

Physician/Medical

2

Completed

Be

မ

Certification:

The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 8m 27 Is marked other than "natural", or Itel

t of Health

permit. Pages 1 Department of H Important: If ital any injury or ott

Baltimore, Maryland 21215-0036

death with the Maryland

Sequentially list conditions, lary, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 menths? 1 ☐ Yes 2 ☑ No

•	c.	Dirth	Fibri
ł		Due to (or as a c	onsequence of):
l	L d		
_	<u> </u>		
	23c.	If yes, outcome of a 1 Live birth 2 [pregnancy □ Fetal death

4□Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

236			tribute to the cau	
	1 ☐ Yes	2 □ No	3 Probably	4 🖫 Unkn
	7			

	1 ☐ Yes	2 🗆 No	3 Probably	4 PUnknow
240	145	24h	Mara autonou fi	ndinan ounulah

	autopsy performed?	prior to com death? lo 1 \(\sum \) Yes 2
26. Place of Death	Check only one)	
ther: 4 Nursing Home	e 5 ☐ Residence	6 □Other (Specify)

prior to death?	completion of	cause of
1 🗍 Ye	2 □ No	

25. Was case referred examiner? 1 ☐ Yes 2 ☑ N	,
27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigatio

	Hospital: 1 ☐ Inpatient 2	ER/Outpatient	3□	DOA
	28a. Date of Injury (Month, Day Yea	28b. Time of Injury		28c.
n			M	

and manner stated.

. Time of		28c. Injury at	
Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No
		1	

ĺ	28d. Describe	now injury	occurred	
l				

a. Certifier	1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6 ☐ Could not be

certifier

Salvia

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

City or Town, State)

	one)			
29b.	Signature	and	title	of

2 Accident

3 Suicide

4 Homicide

29c. License number D0059056 29d. Date signed (Month, Day, Year)

Medical

MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

WEST Royal Ave 1600

Belt 140 21217

11/6/09

State

Registrar

LCT 31. Date filed (Month, Day, Year) NOV 1 0 2004

72. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 4 For State Registra FAMEND ITEM #1 PER PHY G837 11916 ate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year 30 COS ETHEL 31 Ditol GEORGE JACOBS 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Northwest Hospital Randallstown Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) 09 28 5. Social Security Number Birthplace (State or Foreign Country)
 SC **Funeral** Year) 1 ☐ M 2**X** F Director 219-38-7931 67 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, If a Marical Expenses. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6805 Huntington Drive 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: þ Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th grade na Laborer Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James_Bull Ethel Slater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Wright-Daughter 6805 Huntington Drive, Balto, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 11/5/04 Baltimore Co, Md 21. Skinature of Funeral Service Linensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimorem Md 21207 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician (DA) APTIC Heart /Medical Dis to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last intitudes Due to (of as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 10 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 은 ate of Injury (Month, Day Year) 28c. Injury at Work? pletely filled in by the funeral 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation M after death 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours a To the Funeral 6

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) NOV 1 0 2004

29b. Signature and title of certifier

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rthwart 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

Ellobrez 31,

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiend 🛭 🛴 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year KOSIC Green wood Novemba 1127 /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death HOPP tal 5. Social Security Number Kandadstown CONFER HMOVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 213-30-700 Usual Residence of Decedent Director Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 7 is markad othar than "natural", or items 23a or 28a-f show traumatic avant, the Modical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Be Completed by Funeral Director ATTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 CAC 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) omEstic Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Brown ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City Town, State, Zip Code) nt of Health a :: If itam 27 is r or othar trai 20b. Place of Disposition (Name of cometery, crematory or other place) TEOR 15 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 404 21. Signiture of Funeral Service Licensee Address of Facility un 814N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cayse on each line. Approximate Interval Between Onset and Death respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician thenoscler our Corarany Vanwlar /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2□ No 1 Yes 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred . After i 1 Natural 5 Pending Injury safter death. death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral L 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The destination is the destion in knowledge, death occurred at the limb, date and place, and due to the cause(s) and manner as states.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 14422006 Novamber 9, 2001 PHYSICIAN Canter, MD

Registrar DHMH 17 Rev 1/2001

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State

5401 Old

32. Regierar's Signature

Randallition.

Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 1 0 2004

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31. Date filed (Month, Day, Year)

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ING 21213-UU35 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturef", or tems 23a or 28a-f show	hy Cupacit	11. M	BO3 BOw] arital Status □ Never Married □ Widowed 42	1 2□ Marrie	12. Was Arme d 1 🔲 Y	Decedent Evel Forces? Yes 2X No. s, Give or Dates:		3. Was Dece If Yes, spe			gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)			nerican Indian, nite, etc.	
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baltimore, permit. Pages 1 a Department of Hee Importent: If item	once.	-	Donation 5				King M	em. Pa 22. Name ar March	nd Addres	s of Facility		Baltimo	ore,		own, Md. 21202	
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DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte	Certification.	3 4	Suicide Homicide	6 Could no determina	t be ed 28e. P	Place of Injury ouilding, etc.	y - At home, farm, (Specify)	street, factory	, office		2	28f. Location (S City or Tow		Number or A	lural Route Numbe	r,
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State of Maryland / Department of Health and Mental Hygiegen 35591 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Sherman E. Holderman 6, November 2004 2:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre De Grace Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1/11/1921 Birthplace (State or Foreign Country) **Funeral** Days 1**½** M 2 □ F 166-14-2551 Director 83 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at MD Harford Director Havre De Grace 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 S. Market Street 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supply Government permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: if item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Holderman (Unknown) Mary (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Holderman/Wife 415 S. Market Street Havre De Grace, Maryland 21078 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Baltimore/Wash. Crem. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, Maryland 11/11/04 * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 nset and Death **Physician** /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner lo to (or as a conseque of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes Division of Vital to the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/21/0 10 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 30. Name and add ath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 100 | 35592 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Kenneth Heydt **Physician** Year ITE Y Kennel 123 PM 03 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson Greater Baltimore Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 X M 2 □ F Yrs. Director 056-16-0991 06/12/1917 New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exercit straustice notified at 1 ☐ Yes 2 X No Completed by Funeral Director Kingsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 7415 Gilbar Drive 21087 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 'natural' 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F ပ Percy E. Heydt Pearl LIttman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Kevin Heydt (son) 619 Harvest Court Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important; If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC.11/06/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Co. assahn 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Bacterial Meningitis **Physician** WEAK /Medical Due to (or as a consequence of): **Examiner** Epidoral Abcress Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attsnding Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death Check onl one examiner? Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After s after dea, ral Director: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D53156 mon ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adam Road Cochensville MD 21030 t SIMOL MA 54 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗓 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day November 6, 2004 **Physician** 11:20 A M Archie James Hanson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1–18–1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 74 North Dakota 501-42-8202 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rei', or items 23a or 28e-f show Examiner must be nutified at Maryland Anne Arundel Davidsonville 1 ☐ Yes 2 No Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21035 3502 Mobile Ct. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Affried Folces:
1 X Yes 2 No
If Yes, Give
Year or Dates: 1950-62 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 X Widowed 4 □ Divorced White "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other then Mechanic Automobile 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Conrad Hanson Eva Engle 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ff item 27 Marion G. Joyce/ Step Daughter 616 Quaint Acres Dr., Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State perrit. Page Department of Importent: if any injury or once. Lakemont Cemetery 11-8-04 Davidsonville, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee MINT 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) notenian Too veel **Physician** /Medical Due to (or s consequence of) Examiner. Edur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes certificate To the Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 Yes 2 🗌 No investigation 2 Accident within 24 hours after deat. To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my onicion, doubt accurred at the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETYGIE PID SATE 300 AMOST MO 21401 400

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

				1 = For State Registrar	State	of Maryla		artment of rtificate o	Health and	Mental Hy	giene 0	04	35594
				1. Decedent's Name (First, Middl	e, Last)					2. Date of D	eath		3. Time of Death
		Physici /Medi		Robert S. Hunt						Novem	Ber 5	2004	1005AM
•		Examir	ner	4a. Facility Name (If not institution Upper Chesapea	ke Medica		er	Be1			4c. Count	ord	
10:00 AM		Funeral Director		5. Social Security Number 191–16–4849	6.Sex 1 M 2 F	7. Age (In yr	s. last birthday) Yrs.	If Under 1 Ye Months Day	ar If Under 24 Hr ys Hours Mir		ay, Yea <u>r</u>)	9. Birthr Cour Ma	place (State or Foreign ntry) ryland
8		land ow		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation				1	10d. Inside City Limits
0		death with the Maryland ms 23a or 28e-f show rmst be notified at	tor	Pa.	York		Del:	ta					1 ☐ Yes 2 ☐ No
		or 28.	Olrec	10e. Street and Number				10f. Zip Code	9		10g. Citizen of	What Cour	
		ath w	ral	220 Black Oak					17314		U.S.A.		
100/00/11	336	d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 7 is marked other then "neturel", or Items 23a or 28e-1 shov treumatic event, the Medical Everiter must be rediffed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri X 3 □ Widowed 4 □ Divorced	Armed F	2 2 No		Was Decedent of If Yes, specify C 1 ☐ Yes 2 🖾 N	of Hispanic Origin? (uban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No into Rican, etc.)		ce - Americ ck, White, y: Whi t	
=	Maryland 21215-0036	72 hou	Completed	15. Deceden (Specify only highe	t's Education		16a. Dece	dent's Usual Occ	cupation		16b. Kind of B	usiness/In	dustry
_	21	ithin 7	nple	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use ret	ne during most of wi ired)	orking	£:	-1	
	121	iled w Hygier ther th		17. Father's Name (First, Middle,	(act)		Fire	eman	10.11		firefi		ng —————
	and	d be f	Be	Daniel G. Hunts	·					ame (First, Middle		n <i>e)</i>	
	Z	should nd Me mark imatic	To	19a. Informant's Name/Relations	0		19b. Mailir	ng Address (Stre	et and Number or F	es Jumper		State Zin	Code
		nd 2		Robert Huntsber		/son			k Trail,				, 0000)
+	J.	of Head		20a. Method of Disposition		20b.		sition (Name of natory or other p		Date	20c. Location		own, State
bert	Ë	Page nent c		1 □ Burial 2 ☐ Cremation `4 □ Donation 5 □ Other (S		Otate		Cremator		3/2004	Baltim	ore.	Md .
206	Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then eny injury or other treumatic event, II a Magnes.		21. Signature of Funeral Service	3/ (22	Name and Add	ress of Facility k Funeral	L Home of	Bel Ai	r, Ir	ıc.
				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the de- each line.	ath. Do not ent	er the mode of d	ying, such as cardia	ac or respiratory a	rrest,	a. Z1	interval between
		Physician		Immediate Cause (Final disease or condition	_ a c	BUGI	RE B	ILATE	RAL-P	NEUR	10011	1	Onset and Death
		/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):	01		ilur		-	
			40	Sequentially list conditions,	b	or as a conse	176	KGNV	AL FA	Mur	<u> </u>		
2		uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	(0, 40 4 00)	74401100 0175						
20	oʻ	e be executed /sician and e burial-transit	Exa	resulting in death) Last	cDue to	(or as a conse	equence of):					-	
2	8760	ate be physicia the bu	dlcal		d								
2	89)	n certifica anding ph use as th	Med	IF FEMALE:		181				V* 10			
去	. Bo	death e atte d for	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4□Pregr	oirth 2□Fe nant at time of	tal death 3 🗌	Ectopic pregnar Other (specify)				te of delive nth	ny Day Year
3	0.	at the d by the stached	hys	9 Unknown	9□ Unkn								
T	Vital Records, I	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant condition	LON /	eath but not re	Sulting in the ur	TATIC	given in Part I.	- 1	obacco use cont ∕es 2□No	ribute to th 3 ☐ Proba	e cause of death?
	000	law re as bee 2 sho	Completed	URI.	NARY	TRA	ct 1	NAGE	TION	24a. Was	an 24b.	Were autor	osy findings available
	H	The I	Com		1					autor perfo	rmed?	death?	npletion of cause of 2□ No
	/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?						ath (Check only o	- 1		
	of	ding Physician: h. After this certific tuneral director,	To:	1 ☐ Yes 2 No 27. Manner of Death			☐ ER/Outpatien	3 DOA	-	Home 5 Resid)
∞		ding In. After funer	tlon	1 Natural 5 ☐ Pendin		of Injury th, Day Year)	28b. Time of Injury	28c. Inj W	ury at fork? □Yes 2□No	28d. Describe I	now injury occurr	ed	
B	Division	after death. after death. I Director: A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could r	ot be	of Injury - At I	home, farm, stre	eet, factory, office		28f. Location (5	Street and Numb	er or Rural	Route Number
<u>उ</u>	Dİ	alor /	erti	4 Homicide	buildi	ing, etc. (Spec	cify)			City or Tox	vn, State)	0, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	riobie ridinber,
25402 talva		To the Hospitel or Attending Physician: within 24 hours after death: To the Funerel Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifyin 2 Medicel 1	g Physicien: To the Examiner: On the b and man	best of my kn asis of examin ner stated.	nowledge, death nation and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)
Titlah		To th withir To th comp	ž	29b. Signature and title of certifier					nse number		29d. Date signed	(Month, L	Day, Year)
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1	,	4		30. Name and address of person of Portson of	who completed caus	se of death (Ite	om 23a) (Type, F 2 B GUA	Print) HR ROA	D SUITE	, PALLS	TON, M	1D 2	11047
		Sta Registr		31. Date filed (Month, Day, Year)	A N	legistrar's Sign	nature A	sould			-		
				NOV 1 0 2004	/ /allywy	/	- /7						

atient Known as Mary Harri

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requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, or Attending Physicien: the Hospitei

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35595 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Ε. Harris 12:40 AM November 2004 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Hospital of Baltimore Baltimore city

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 87 Director Yrs 099-20-5441 02 14 17 NΫ́ Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location ?7 is marked other than "naturel", or items 23e or 28e-f show treumatic event, the Modical Examiner is use by notified at 10d. Inside City Limits Director XX es 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3630 Manchester Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3€Widowed 4 ☐ Divorced Specify. Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Nurse Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be ind Mental I Tom Harris Mary E. Harris Sr. 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health an.
Importent: If Item 27 is m.
any Injury or othe-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marshall P. Murphy-Son 3630 Manchester Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ^ 4 □Donation 5 □ Other (Specify) Holly Hills Cemetery 11/11/04 Middle River, Md 21. Signature of Funeral-Service Licensee 22 Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter th, disease, or complications that seused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause of each line. 21215 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sep5.5

Due to (er as a consequence of): resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown nsulin dependent Diabetes Mellitus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Artery Disease autopsy performed? 2 No 1 Yes 2 No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November, 8, 2004 H Busha MI RES-000

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death.

State Registrar

DHMH 17 Rev 1/2001

Hospital of Baltimorse

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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82. Registrar's Signature

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NOV 1 0 2004

State of Maryland / Department of Health and Mental Hygie () [] 35596 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lorenzo Haywood November 08, 2004 10:15AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F 239-24-4331 82 10-07-1922 Director North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "neturel", or Items 23a or 28a-f show 1 Yes 2 No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5060 Carmine Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 21 No Specify: Specify: Ď 3 Widowed 4 Divorced Black. or than "neture the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Robert Haywood Beula Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 99 permit Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any in ury or other trau Jane T. Haywood/Wife 5060 Carmine Avenue Baltimore, MD 21207 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 4 ☐ Donation 5 ☐ Other (Specify) 11-09-04 Metro Crematory Catonsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Baltimore, Mu 21217 and. Enter the discrete f complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** EDSTS DUE TO PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** RENAL FAILURE Sequentially list conditions Due to for as a consequence of Examiner cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as by the attending tached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an this certificate has autopsy perform page 2. No 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X'No 2 1 Inpatient 2 ☐ ER/Outpatient 3[] DOA 27. Manner of Death 28a. Date of Injury (Month, Day) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funerel 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limited Description of the basis of examination and/or investigation in my anising. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and til n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) 5 to 1 1 32. Registrar's Signature

ve Towson,

Maryland 21204\

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State of Maryland / Department of Health and Me	ntal Hygien	004

35597 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** NOV. ELIZABETH IRENE HENDRICKS 2004 12:58 A /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LORIEN NURSING AND REHAB COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2\ F Months Hours 216-18-0761 Director 88 JULY 9, 1916 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturat", or items 23a or 28e-f show any injury or other traumatic evant, Ina Modical Examinar traust be rediffied at once. 1 ☐ Yes 2 No Director HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 CEDAR LANE 21044 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 3X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th OFFICE WORKER RALEIGH HABERDASHER CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FLAVEY WILLIE CORA SANTMYER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELIZABETH DALTON/NIECE 28 RYEWOOD CIRCLE, HOMOSASSA, FLORIDA, 34446 20a. Method of Disposition

D Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) IVY HILL CEMETERY 11-05-04 LAUREL, MARYLAND 22. Name and Address of FacilityFLECK FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee em Struart 7601 SANDY SPRING ROAD, LAUREL, MD, 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician neumonia one Werk /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown yd bengis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. peq 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 00000000 24a. Was an autopsy performed? Yes 2 No certificate has 1∏ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 virsing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2€No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Matural 5 Pending Injury after death. 1 Yes 2 No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C letiqsoH ett oT Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D003192 November 3 2004 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5450 Knoll North 122 olewi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2004

State of Maryland / Department of Health and Mental Hygien 2004 35598 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 08 HEMSON Year Physician MILDRED 2004 10:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CENTER RANDALLSTOWN BALTIMORE MORTHWEST HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Min Months Days Hours 1 M XX 82 220-18-7450 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10b. County or 28e-f show treumetic event, the Medical Examiner must be notified at 1 TYes XXNo Director Owings Mills MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 U.S.A. 21117 9662 Devedente Drive Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mark-Up Clerk U.S Postal Service 12th grade 4yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H tent: If item 27 Is marked ot Lena Swearinger Edwin Burton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9662 Devedente Drive, Owings Mills, Md 21117 John Henson-Husband other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If eny injury or ODCE. * 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. 11/17/04 Owings Mills, Md 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md 285. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIO VASCULAR DISEASE . a. HYPERTENSIVE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ZNo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à s been signed to should be det Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, IBRILLATION . 1 Yes 2 No 3 Probably 4 Unknown CEREBRO VASCULAR DISEASE . 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2/Z the Hospitel or Attending Physicien; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Datient Certification: To 2 ER/Outpatient 3 DOA 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 9 4 27 23 HYSICIAN 29b. Signature NOVEMBER OS uno BOSPITAL 30. N. NORTHWEST Name and address of person who completed cause of death (Item 23a) (Type, Print) HARISH VERAHALLI M OLD COURS ROBP 5401 32, Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 6 2004 Registrar

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	Physici	20	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
	/Medi		John Jackson		Novembi	2 3 2004 2:05 PM
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Francis		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Baltimore City If Under 1 Year If Under 24 Hrs. V	8. Date of Birth	N/A 9 Birthalago (State or Famiga)
	Funeral Director		579-84-7236 18M 20F 34 Yrs.	Months Days Hours Min.	(Month, Day, Ye	3.
	pu »		Usual Residence of Decedent			
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\$	with Se of	ī				Citizen of What Country?
8	death ms 2:	Funeral	2706 Talbot Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R		14. Race - American Indian,
و	after or ite	Fur	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		lican, etc.)	Black, White, etc.
phn 5-0036	filed within 72 hours after Hygiene ther than "neturel", or ite int, ILE Medical Evarina	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 Yes 25 No Specify:		Specify: Black
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2	d withir jiene. r than	ЭШС	Elementary/Secondary (0-12) College (1-4or 5+)	N/A		11/0
3 5		Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name ((First, Middle, Mai	den Sumame)
7 2	Mental arked o	To B	John F. Jackson Sr.	N/A		
known	and and sm			iling Address (Street and Number or Rural	Route Number, Ci	ity or Town, State, Zip Code)
-	C # 0 F		Mae Streater / Mother 270	o Talbot Rd. Balta	. MD	21216
fatint altimore.	T if		TES Definit 2 Defendation 5 Differnoval norm State	position (Name of Da Pematory or other place)		c. Location - City or Town, State
et et et et et et et et et et et et et e	permit. Pag Department Importent: I any njury o		'4 Donation 5 Other (Specify) wood la	wn Cemetery 11.08		
Ba	permit. Pag Depertment Importent: I any injury o		21. Signature of uniteral service Li, 41536			neral Itome
			23a can determine the disease, or complications that caused the death. Do not end or heart failure. List only one cause on each line.	1605 Liberty Heigh	respiratory arrest.	Approximate
	Pnysician		Immol a Cause (Final		h 1 0	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	ntravascular Coag	ulation	2 days
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- 2	p t	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		1	1
	ecute and trans	Examiner				
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Box	ath certific attending p for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
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P.O.	that the di ed by the detached	hys	9 Unknown 9 Unknown		_	
Ś	res tha	by	Part II. Dther significant conditions contributing to death but not resulting in the			co use contribute to the cause of death?
oro	w requir been s should	eted	End-Stage Renal disease, End Stage	caratomy opathy,	1 Tes	2 No 3 Probably 4 XUnknown
ec	e law has b	mple	Jeizure disorder		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Division of Vital Records,	icien: The l certificate ha ector, page				performed 1 ☐ Yes 2	? death? No 1 ☐ Yes 2 ☐ No
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o	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28	d. Describe how in	e 6 ☐Other (Specify) injury occurred
ë	ttending I death. ctor: After / the funer	Certification:	1'XNatural 5 ☐ Pending (Month, Öay Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No		
<u>≤</u> :	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28	f. Location (Street City or Town, St	and Number or Rural Route Number,
۵	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the					·
	Hosp 24 hou Fune fune	Medical	29a. Certifier Check only one) Check only one) Check only one)	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the cause at the time, date	e(s) and manner as stated, and place, and due to the cause(s)
	vithin 2 Vo the	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	E 3 F 8		M. X in	RES- 000		
	À		30. Name and address person who completed cause of death (Item 23a) (Typi	e, Print)		ember 3, 2004
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1	1906		O COI GE TOUCH TO STITULE TO ST	pital of Daltimore		
4	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 0 2004 32 Registrar's Signature	Mai or Dallimole		

State of Maryland / Department of Health and Mental Hygiene 35600 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Willie Jackson 04 Nov. 2004 2:03am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1**X**M 2□ F Hours Min. Yrs. Director 267-16-9422 09/03/1922 Florida 82 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1XYes 2 □ No Directo Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 626 Water Street 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by Specify: White 3 Widowed 4 Divorced Year or Dates: 1942-45 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Gun Mechanic U.S. Government 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental h ပ Grovine Hogans Willie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is rr any injury or other treum once. 105 Turnberry Dr., Avondale, PA 19311 Robert Antonow- Executor Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Grdns. 11/06/04 Aberdeen, MD ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 23ar Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** da /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine certificate be executed burial-transit Cause (Cissasse or injurthat initiated events resulting in death) Last attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has The Chimie **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. UNION AVE. HAVRE DE GRACE NO. Galvez M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Makeeya A. Johnson State of Maryland / Department of Health and Mental Hygiene UNK 04-359 004 3560 l 04-7063 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2, Month **Physician JOHNSON** MAKEEYA 2004 12:12a NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 5606 16th AVENUE apt 303 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES HYATTSVILLE 8. Date of Birth (Month, Day, Year) May, 4, 1986 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days Maryland 1 □ M 2 🕏 F 18 217-11-6232 Director Usuat Residence of Decedent 10c. City Town or Location 10d. Inside City Limits with the Maryland r 28a-f show 10a State 10b County 1 Yes 2 No **Funeral Director** MD MONTGOMERY Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral', or Items 23a or Exeminer must be a 20879 20630 Prathertown Rd U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) College (1-4or 5+) 911 Home 10th Domestic other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic event ODGS. Be Marvin 2 Johnson <u>Vicki Prather</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand Willistine Prather-mother 20630 Prathertown Rd Gaithersburg, MD20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donardo 5 ☐ Other (Secrify) Brooke Grove Cem 11/10/04 Gaithersburg, MD 22. Name and Address of Facility Snowden Funeral Home, P.A. of Funeral Service Lice 21. Signature 246 N Washington St Rockville, MD20850 23a. Part1. Enter the disea shock, or heart failure. Approximate tnterval Between Onset and Death e, or complications that caused the death List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, GUNSHUT Immediate Cause (Final WOUND OF HEAD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial-t physiclan s the burial 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death P.O. the 9 Unknow 2 signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▶ Pes 2 □ No 24a. Was an autopsy performed Yes 2 No Hospitel or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner's Other: 4 Nursing Home 5 Residence XXOther (Specify) SCENE Hospital: 2 1XX es 2 No 1 Inpatient 2 EN/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After ZO3 A 1 Natural SUBSKLT WAS SHUT death. 1 Yes investigation 11/2/04 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) BEPROOM UFARALT MENT 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 566616771 NVENIX 3 Suicide 4 Homicide ADT 303 HYATTIVILLE 24 hours a e Funeral I | Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manufer stated. (Check only one) the within 2 To the 29d. Date signed (Month. Day. Year) 29c. License number 29b. Signature and title OCME NOVEMBER 2, 2004

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30. Name and ag

dress of person who complete

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Registrar
DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland 21201

NO

32. Registar's Signature

cause of death (Item 23a) (Type.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Ty Year 2. Date of Death 3. Time of Death **Physician** REDERICK DHNSON November 4 20 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14/west 1105 repul STOWIN move If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number Funeral 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Year) 238-40-778 Usual Residence of Decedent 1 M 2□ F Director with the Maryland 10a. State Count 10b 10c City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 Nes 2 No Director 10e. Street and Number 10g. Citizen of What Country? B UR death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) ucation Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, onnsor DSDFR 19a/Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20c. Location - City or Yown, State 20a. Method of Disposition Date Pages 1 nent of H ent: If Ite 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Sign u re of Funeral Service Licensee R. Lun. onEs 23a. Part1. Enter the disease, or complications that caps shock, or heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastalie disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760 Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ primary (ande Renort 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one examiner? 1 thpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 240 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After To the Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30 Name and address of pers in who completed cause of death (Item 23a) (Type, Print

State

Registrar

Kanlaram

0 2004

32. Restrar's Signature

State of Maryland / Department of Health and Mental Hygien 35603 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Jewell 2004 7:15 A^M 04/Medical Nov. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Clinton Nursing & Rehab. Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 12, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Birthplace (State or Foreign Country) **X**X M 2□ F 93 Director 578/34/5430 1911So.Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 ☐ No Director Clinton Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735-2712 9211 Stuart Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: White Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: if item 27 is marked other than *r any injury or other traumatic event, the Med 2016s. than Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Unknown Unknown Private Ind. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roy A. Jewell Sally Mae Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda S. Eckles (Niece) 410 O Street S.W., Wash. D.C.20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crem. 11/9/04 Riverdale. Maryland 22. Name and Address of Facility Tri-State F/S/Inc. 21. Signature of Funeral Service Licens Third St. N.W. Wash, D.C. 20001 Cart1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical **Examiner** 1150 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons equence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 210 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Jas certificate ha autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27. Man er of Death Medical Certification; 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) | 29b. Signature and title of ceptitier 29c. License number 29d. Date signed (Month, Day, Year) Name and ad ess of person o completed cause of death (Item 23a) (Type, Print) NUISING 31. Date filed (Month 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiepen 1 - For Stete Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month William J. Johnson, Jr. 2004 November 9:10 Αм /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 128 Springside Drive Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Yrs. Director 215-58-3877 53 Mary Tand March 6. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatih and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23a or 28a-f shoy ury or other traumatic event, the Medical Examinar must be notified at 28a-f show Director 1 ☐ Yes 2X No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Springside Drive 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 XNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ð Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Melvin Benhoff Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Paving Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J. Johnson, Sr. Marion F. Brydges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion F. Johnson / mother 128 Springside Drive; Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ↑ 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Hilltop Service Corp. 11/9/04 5 Other (Specify) Towson, MD 21. Signature of Funeral Pervice Cicenses 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Deat **Physician** 5 years /Medical **Examiner** Sequentially list conditions, Examiner Directo (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifie 29c. License number November 8, 2004 18667 mpleted cause of death (Item 231) CT. Latherville, MD 32. Registrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene 35605 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day W. KELLY **Physician** Year SAL IE 0 1,00 F Nova /Medical 2004 Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Dee Examiner 101 If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year Date of Birth 6. Sex 9. Birthplace (Stete or Foreign **Funeral** 214-22-9843 Usual Residence of Decedent Days 1□M 21 F Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mantel Hygiene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic avant, the Medical Examiner must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No Varyland more 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? d. 2 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 14. Race Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced 314 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Baltoc ner 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Vhiting zer ohn 19a. Informent's Name/Relationship (Type, Printy) (niece 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Balto. Md. 21217 10 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition

1 B.Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State 11/10/2004 Mem. Par 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

JOSEPH L. RUS 21. Signature of Funeral Service Ligensee Funeral Home Ave Barto, Md Joseph L. Kuss 2222 W. North Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failings. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical SOND Examiner Due to (or es a consequence of): Physician/Medical Examiner oxysmel ate has been signed by the attanding physicien and pege 2 should be datached for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? within 24 hours after death.

To the Funeral Director: After this cartificate has I completely filled in by the funeral director, pege 2 or 1 Tes 2'PNo 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes 2□ No 27. Manner of Death 1 D Naturel 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. 29b. Signature end title of certifier 29d. Date signed (Month, Day, Yeer) D36942 2004 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) . Coperfice, no 2/22 TURAKUIA Nedwick 150 31. Date filed (Month 0 2004 32. Pegistrer's Signature State Frence Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 0 0 1 35606 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Year Physician ROSE LUKENICH 14:27 30, 2004 OCTOBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) プロトルト トロアベエルト BAYVIEW MEDI 4b. City, Town, or Location of Death Examiner EDICAL CENTER BALTIMORE, MARYLAND N/A 4940 EASTERN AVENUE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 7, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1□M 2QF Yrs 72 1932 PA. 215-28-6472 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 Tyres 2 No Director MD. N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 219 S. CALHOUN STREET 21223 U.S.A. death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Importent: If item 27 is marked other than "natural", or iten any injury or other freumatic event, the Modified Examinat 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) LIOUOR 11TH BAR MAID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ANNA UNKNOWN HERMAN MEEKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 S. POTOMAC ST., BALTIMORE, MARYLAND TERRY BACHMAN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State OAK LAWN CEMETERY * 4 ☐Donation 5 ☐ Other (Specify) 11/3/04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician ADULT RESPIRATORY DISTRESS SYNDROME disease or condition resulting in death) BLEVEN DAYS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, it any, leading to in mediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-transit certilicate be executed TENAL FAILURG DAYS that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown ORSTRUCTIVE PULMONARY DISEASE CHRONIC peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an ANEMIA autopsy performed? Yes 2 No has page 2 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Npatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Injury 1 Natural 5 Pending efter death.

I Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours e To the Funerel I 29a. Certifier TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe M.D RESOUL OCTUSER 30, 2004

Registrar

10

State

31. Date filed (Month, Day, Year)

NOV 1 0 2004

4940

EASTERN AVENUE; BALTIMORE, MARYLAND 21224

M.D

32. Registrar's Signature

ar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURYAPRASAD

			For State Registrar	State of Man	yland / Dej <i>C</i> e	partmei <i>ertifica</i>	nt of He te of D	eath		Reg. No.	_	35607
	Physicia		1. Decedent's Name (First, Middle, Las HOWARD	it)		L	ITZA	AU	2. Date of Dea Month	Day		3. Time of Death
	/Medic Examin Funeral Director	er	5. Social Security Number 6. S 216-28-3362	SPITAL	n yrs. last birthda 73 Yrs.	B	ALTIN er 1 Year	ocation of Dea	s. 8. Date of Birtl	4c.	N/A 9. Birt	hplace (State or Foreign untry) RYLAND
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or	Location						10d. Inside City Limits
	89-fs	ctor	MD BALTIM	ORE	EI	DGEME	RE					1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number			10f. Z	ip Code	0.1.0		10g. Cit	izen of What Co	untry?
	s 23a	Frai	2208 LINCOLN A	VENUE 12. Was Decedent Eve	- II C 11	3 Was Doo		219	Specify Ves or No.		USA 14. Race - Ame	nican Indian
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "neturel", or Items 23a or 28e-f show imatic event, it a Macinal Examiliar must be indiffed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 9			ecify Cuban,		Specify Yes or No- ino Rican, etc.)		Black, Whit	
Ö	r2 hou	ted	15. Decedent's Ed (Specify only highest gra	lucation		cedent's Us	ual Occupati	ion ring most of w	orkina	16b. K	ind of Business	
215	ithin 7 18.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					Unking			
7	filed wi Hygien Ither th	Co	8	0	ASS	SEMBL	Y LI		(First Middle		NERAL I	MOTORS
and	be fill had had had out	Be	17. Father's Name (First, Middle, Last) HOWARD MILTON				'		ame <i>(First, Middl</i> e, GREEN	Maiden	Sumame)	
2	hould d Mer marke	၉	19a. Informant's Name/Relationship		10h Ma	ailing Addre	ss (Street an		Rural Route Number	er City (or Town State	Zin Code)
Z Z	id 2 s Ith an 17 Is r treur		SUSAN LITZAU S		4							21122
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic evones.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specific	Removal from State	20b. Place of Dis cemetery, c	sposition (Natrematory or	ame of other place))	Date 110/04	20c. L	ocation - City or	Town, State
Baltir	permit. P Departme Importen any injur.		21. Signature of Funeral Service Licer			CA CZC	ROWS	K Facily UN	NERAL HO VE. BALT)ME	P.A.	
			23a. Part1. Enter the disease or com shock, or heart failure. Eist only	plications that caused th							JKE, FII	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a ESOPH			Cı	ANCE	R			Onset and Death
	Examiner		Conventially list conditions		VG	NOD	ULE					INEEK
	7 = 3	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a c	or sequence of t							
68760,	tificate be executed ng physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):							
687	ifficate g phys	edical		. d								
.O. Box	attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at tin 9 Unknown	Fetal death	3 □Ectopic 5 □ Other (23d. Date of de Month	livery Day Year
۵.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	e underlying	inderlying cause given in Part I.			23e. Did tobacco use contribut		o the cause of death?
Records,	ne law req has beer ge 2 shou	Completed	ANAEMI	A					24a. Was autor perfo	osv	prior to	utopsy findings available completion of cause of
Viital		e C	25. Was case referred to medical					26 Place of D	eath (Check only o		o 1 ☐ Yes	2 No
		OB	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient	2 ER/Outpat	tient 3 0			Home 5 Resi		6 ☐Other (Spe	ecify)
Division of	ling Ph	ation: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time	e of	28c. Injury a Work?	at		escribe how injury occurred		
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc.		street, facto	ory, office		28f. Location (City or To	Street a wn, Stat	nd Number or R e)	ural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	edical	29a. Certifier 1 🔀 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of one of the basis of example; On the basis of example and manner state	xamination and/or	eath occurre r investigation	d at the time on, in my opi	e, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s date an	s) and manner and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier				9c. License				ate signed (Mon	
,			Janakis	- MD			RK5	001	1	NOVE	EMBER	09 2004
	10		30. Name and address of person who	completed cause of dea	th (Item 23a) (Typ	pe, Print)	1 [J-A - 1]	IFA ATI	PEET BAL	TIM	ORE. M.	21225
	Sta		31. Date filed (Month, Day, Year)	82. Registrar's	s Signatur		MANU	VERSI	CC COND		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, -(LLJ
	Registr	_	MOV 1 (1 2004	Christian		ADON.	000					

State of Maryland / Department of Health and Mental Hygie (Pen) 35608 1 - For Stata Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Rose Margaret LoPresti November 5, 2004 2:57 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 7, 19 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2√F Yrs 85 Director 217-03-4657 1919 Pennsylvania Usual Residence of Deceden 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Baltimore 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8511 Old Harford Road, Apt. D U.S.A. 21234 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Meat Wrapper Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked of any injury or other traumatic eve John Moscato Carmela Suttalaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Castino (grandson) 7821 Daniels Avenue, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Gardens of Faith 11/09/2004 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER - metastatic Physician rensT disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 + OCY tomA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 🗌 Yes 2,80 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number November 5, 2004 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Bolts Md 21205 6701 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 1 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 L For Stata Ragistra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 2004 7:34PM Lim Chong J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery 2853 Aquarius Avenue 8. Date of Birth (Month, Day, Year) Sept. 30,1940 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 1 ☐ M 2 🖾 F 64 Sept. 231-31-9792 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State "natural", or Items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Silver Spring Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20906 2853 Aquarius Avenue death v Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Haalih and Mental Hygiene Importent: If Item 27 le marked other then "natural", or Item any injury or other treumetic event, the Madical Examin 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: Korean Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Tailor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bong Shim Park Ki Hyup 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2853 Aquarius Avenue Silver Spring, Maryland 20906 Young H. Lim (Spouse) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal from State National Memorial Park 11-8-2004 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility National Funeral Home M00869 Falls Church, VA 22042 7482 Lee Highway r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lear failure. List only one cause on each line. Approximate Interval Between Onset and Death Part1. Ent Immediate Cause (Final CARCINOM A PANCREATIC Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MONTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No 3 Probably 4 Unknown ASCITZS MALIGNANT 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 146 24a. Was an Jas page 2 autopsy performe 2 No 1 ☐ Yes certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 1 No this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) Medi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04 11 www npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who cor h arre 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10:37 A M November 7, 2004 Catherine M. Lee /Medical 4b. City. Town, or Location of Death 4c. County of Oeath 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Funera! 1 ☐ M 2 🖾 F Yrs. 87 November 24, 1916 Ohio 579-30-4624 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Tyes 2 XNo Directo Maryland Montgomery Cabin John 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö Pages 1 and 2 should be filed within 72 hours after death with Items 23a 20818 United States 8025 Riverside Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☒ No Specify: White 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Registered Nurse 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Bohn ပ Michael Magner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patrick B. Lee/ Son 8025 Riverside Drive, Cabin John, Maryland 20818 other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. Date 20c. Location - City or Town, State 20a. Method of Disposition 0 November 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 22. Name and Address of Facility Robert A. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Pumphrey Funeral Home/ 7557 Wisconsin Avenue 21. Signature op Funeral Service Licenses Bethesda-Chevy Chase Inc Bethesda, Maryland 20814 M01405 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of) **Examiner** Cardiomyopathy Sequentially list conditions, Due to (or as a consequence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): 68760, the death certificate be Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown Š ے signed t 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 🔀 No this certificate Vital Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Medical Certification; After Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation within 24 hours after deau...
To the Funeral Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D

State

Registrar

30. Name and address

31. Date filed (Month,

Alpana Goswami,

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

09

D 27660

11119 Rockville Pike, #G100, Rockville, Maryland 20852

State of Maryland / Department of Health and Mental Hygien [] []

35611

		1 - Stete Registrer		Ce	rtificate of Deatl	h	Reg.	No.	33011
Dhysia		1. Decedent's Name (First, Middle, Las	t)			2	. Date of Death		3. Time of Death
Physici /Medi		GEORGE	C. MCMANN			/	Vovember	3 2004	04:37
Examir		4a. Facility Name (If not institution, give	n medical Co	Will	4b. City, Town, or Location	n of Death		4c. County of Death	
. Funeral Director		210-40-0091	7. Age (In yrs. 58	last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8 Min.	Date of Birth (Month, Day, Ye Lober 27,	ar) 9. Birth Con 1946 Vi	nplace (State or Foreig untry) rginia
the Maryland 28a-f show notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Somers		y, Town or Lo	cation Crisfield				10d. Inside City Limits
uth with the 23a or 28u	Funeral Director	10e. Street and Number 2883 Byrdtown Road	B		10f. Zip Code 21817			Citizen of What Cou	intry?
re, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland fleath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Marical Exercitive Francisco at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U Armed Forces? 1 (2) Yes 2 (1) No 196 If Yes, Give Year or Dates: 196	66-	Was Decedent of Hispanic C If Yes, specify Cuban, Mexicon 1 ☐ Yes 2 ☑ No Specify	an, Puerto Rio	y Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Whi	etc.
	Be Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working		. Kind of Business/In	,
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, ILEM ance.	To Be C	17. Father's Name (First, Middle, Last) John Wesley McMann	1				First, Middle, Maid Crockett	den Sumame)	
Alary 2 sho and 1 ts me		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (Street and Numi	ber or Rural F	Route Number, Cit	y or Town, State, Zi	p Code)
e, N 1 and 1 and 1 ealth 1 am 27 ther tu		Darlene M. Pruitt 20a. Method of Disposition			Byrdtown Roa				
Baltimore, sermit. Pages 1 as Department of Heampointant: If item my injury or othe once.		1 □XBurial 2 □ Cremation 3 □ I	Removal from State	emetery, crer	sition (Name of natory or other place)	Date		Location - City or T	
Iltin		' 4 □ Donation 5 □ Other (Specify,			Memorial Park	11/05/		risfield,	MD
Bal perm Depa Impo any i		Kolux 11 1st	snaw, Jr	Br	Name and Address of Faci Tadshaw & Sons 16 W. Main St.	Funer	al Home	MD 21817	7
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death	REN	er the mode of dying, such a AL FAILM	s cardiac or re	espiratory arrest,	2101	Approximate Interval Between Onset and Death AD A45
certificate be executed ding physician and se as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).		LL LYM	n P Ho	MA		20 DAY=
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
Records, P.O. Bo The law requires that the death the has been signed by the atter aggs 2 should be detached for a		Part II. Other significant conditions co	ntributing to death but not resu	ulting in the ur	nderlying cause given in Part	I.		o use contribute to t 2 ☑1√No 3 ☐ Prot	the cause of death?
	Completed						24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
f Vital Reysician: The is certificate hidirector, page	Be (25. Was case referred to medical examiner?					heck only one)		
Of Physical this of all directions of the control o	T.	1 Yes 2 No		ER/Outpatien	3 DOA Other: 4 N			6 ☐Other (Specif	ý)
vision of Vital Attanding Physician: r death: actor: After this certifice by the funeral director, t	Certification:	1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2]No	. Describe how in		
Divi	Sertif	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office	28t.	City or Town, Sta	and Number or Rura ite)	il Route Number,
Divisio To the Hospital or Attandi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Medical (29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medicel Exemi	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time, date at estigation, in my opinion, dea	nd place, and ath occurred a	due to the cause at the time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)
To the within To the comp	×	29b. Signature and title of certifier	1 elem	y No	29c. License number D 4 6	962		vem Ber	Day, Year) 03, 2004
り	J.	30. Name and address of person who co	empleted cause of death (Item, $M \cdot D$. $PENI$		Print) REGION	JAL M	EDICAL 57 SAL	CENTER.	MD21801

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Registrar

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State of Maryland / Department of Health and Mental Hygie 2004 356 12

		•	For State Registrar	Otate of Ivia		Certificate of			J. No.	30012		
	Physicia		1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year 2001	3. Time of Death		
	/Medic	al .	Elizabeth	Q. Mack	<	th City Tourn	at Legation of Dooth	November	6 2002 4c. County of Deat			
	Examin	er	4a. Facility Name (If not institution, gi 9423 Longs Mi				cky Ridge		Frede			
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birth			8. Date of Birth	Q Birt	hplace (State or Foreign		
	Director		220-60-2/63	1□M 2★1F	78 Yr	s. Northis Days	110013	Jan. 21	, 1926 E	Burma		
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits		
	Mary -f sho	to	PA Fran	klin		Greencast	le			1 MYes 2 □ No		
	or 28a	Director	10e. Street and Number	1		10f. Zip Code		109	g. Citizen of What Co	•		
	ath wi	rai	7980 Golf Vis		- : :: 2		7225		United k			
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Tyes 2 15		13. Was Decedent of I If Yes, specify Cub		Rican, etc.)	Black, White	e, etc.		
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or itema 23s or 28s-f show imatic event. It a Medical Examinar must be notified at	þ	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specify: V	/hite		
5-0	72 ho 'natur	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	(ecedent's Usual Occu Give kind of work done	during most of work	ring 10	6b. Kind of Business/	Industry		
21215-0036	within ane. then	mpl	Eiementary/Secondary (0-12)	College (1-4or 5	+)	ife. DO NOT use retire V accounts		ative	ng			
0	filed withi Hygiene. other than		17. Father's Name (First, Middle, Las	st)	110	, accounts		e (First, Middle, Ma				
a	should be nd Mental marked c	To Be	Sydney George	Quick			Magde	elene Cha	rlotte Dra	agon		
ary	2 should and he is man		19a. Informant's Name/Relationship			Mailing Address (Stree						
Z,	and ealth m 27		Glynis Dalgarn/	niece		+59 Longs M	rate at	4	Ridge, MD			
Baltimore, Maryland			20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3			Disposition (Name of crematory or other pla		_				
	permit. Page Department Important: II any injury o		*4 ☑Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Up	A	ATT COL	unty Cremat			Sykesville neral Home	·		
Ba	Depriment important	<u> </u>	MYUQ Z.	Bothe	K				o, MD 2179			
Ą	of the state of		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Occupant Death Death									
}	Physician		Immediate Cause (Final disease or condition	Pneum	onia rig	ht lower l	obe			Onset and Death 1 mo.		
	/Medical Examiner		resulting in death)		a consequence of	hemorrhag	_			1 mo.		
L		er	Sequentially list conditions, if any, leading to immediate	h	a consequence of		e -			1 11O .		
	uted d ansit	Examin	Eagueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	End S	tage COP	D				yrs.		
ó	e exectian an		resulting in death) Last	Due to (or as	a consequence of):						
68760,	tificate be executed og physician and as the burial-transit	fedical	•	d								
_		/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_			23d. Date of de	livery		
Box	that the death cert ed by the attendin detached for use :	by Physician/N	in the past 12 months?	4 Pregnant at	2 Fetal death time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _			Month	Day Year		
P.O.	at the by the tache	hys	9 ☐ Unknown	9□ Unknown								
	uires tha signed d be det		Part II. Other significant conditions Pulmonary Hype		ut not resulting in	the underlying cause g	ven in Part I.		acco use contribute to	the cause of death?		
ord	w requir been s should	eted	Cachexia	21 (2113 1011					1957	utopsy findings available		
Rec	e lav has	Completed						24a. Was an autopsy perform	ed? prior to death?	completion of cause of		
<u>a</u>		e Co	Aortic Aneury: 25. Was case referred to medical	sm			26 Place of Dea	1 ☐ Yes 24 th (Check only one	□No 1□Yes			
>	ysician: is certific director,	0 8	examiner? 1 ☐ Yes 2 █ X No	Hospital: 1 Inpatie	ent 2 ER/Out	patient 3 DOA				sister's cify)residence		
0 0	Attending Physician: r death. ector: After this certific by the funeral director.	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Ti	ury Wo	ork?	28d. Describe how				
sio	tendi Jeath. tor: A the fu	cati	2 Accident investigat 3 Suicide 6 Could not	the second	une. At home, for]Yes 2□No	28f Location (Stre	eet and Number or Ri	uml Route Number		
Division of Vital Records,	i Dife	Certification:	4 ☐ Homicide determine	building, et	c. (Specify)	m, street, factory, office	·	City or Town,	State)	J. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		
	To the Hospital or Attenwihin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge,	death occurred at the	time, date and place	, and due to the car	use(s) and manner as	s stated.		
	the Holin 24 the Fu	fedical	one)	aminer: On the basis of and manner sta	ated.							
	To To	2	29b. Signature and title of certifier	, Kei	lle.	MD 290. Licer	D54749	29	d. Date signed (Mont			
•	h	- 5	30. Name and address of person wh	no completed cause of c	leath (tem 3a)	(vpe. Print)	74/42		1400.0,	200-1		
	J		Allen Reilly, M	D 801 Tol	1 House	Ave., D-1,		k, MD 217	701			
	Sta Regist		31. Date filed (Month Pay Year)	2004 32. Registr	ar's Signature	5 Spor	Kal					

			1 - For Stete Registrar	State o	f Marylan		artmen			and M	lental Hyg	giene	11.	35613
	Physici		Decedent's Name (First, Middle)		illie J.	Martir	1				2. Date of Dea		Year	3. Time of Death 5:30 Pm. м
	/Medio Examir		4a. Facility Name (If not institution,	give street and nur		7.20.	4b. City,	Town, or	Location o	of Death		4c. County		
	Funeral Director				7. Age (<i>ln yrs</i> . 69	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day Apr 2,	, Year)	Col	iplace (State or Foreign Intry) Georgia
	ryland	_	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	th the Ma or 28a-f s	Funeral Director	Maryland 10e. Street and Number	N/A			10f. Zip		timore		1	log. Citizen of \	1 [*] Yes 2 □ No zen of What Country?	
	23a c	alD	6214 Plymouth Rd						2121	4	U.S.A.			٦.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23e or 28e-f show shi righty or other traumatic event, the Medical Examinar must be notified at ance.	by	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 No /e		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ck, White	ican Indian, , etc. Black
5-0	72 ho netur	sted	15. Decedent' (Specify only highest			16a. Deced	ient's Usua kind of wor	l Occupa	ition	of worki	na	16b. Kind of B	usiness/li	ndustry
2121	ed within /giene. er then "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	e retired)	oorer	OF WORK	Construction			
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other then aumatic event, the Ms	To Be	17. Father's Name (First, Middle, L	ast) ie Martin					18. Mothe	r's Name	ne (First, Middle, Maiden Sumame) Lucille Beasley			
	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationsh Annabelle Martin Wife								Route Number Maryland 21		State, Zi	p Code)
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 eny injury or other tr. 2005.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			lace of Dispo emetery, cren Kina!	sition (Nam natory or ot	her place	,		1/11/04	20c. Location -	•	own, State , Maryland
Balti	permit. Departm Importe eny inju			21. Signature of Fundral Service Licensee 22. Name and Address of Facility Ester Brothers Fundral H 1300 Futaw Place Baltim 23a. Part 1. Enter the disease, or our plications that caused the death. Do not enter the mode of dying, such as cardiac or resishock, or heart failure. List only one cause or each line.								21217		
00,	Physician / Medical Examiner points it is partially transit the prival transit	l Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially flat out ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or as a consequence or a consequence or a c	uence of):	TO.	F1	UNG	' W	UHL N	m#s		Interval Batween Onset and Death
P.O. Box 68760,	The law requires that the death certificate b tle has been signed by the attending physic page 2 should be detached for use as the b	Physiclan/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	egnancy ecify)				23d. Dat		ery Day Year				
	w requires that been signed should be de	by	Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the ur	nderlying ca	use give	n in Part I.				ibute to t	he cause of death?
Il Records,		Completed		/							24a. Was ar autops perform 1 🗆 Yes 2	ned?	Vere autorior to colleath?	opsy findings available impletion of cause of
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Other		of Death	(Check only on	9)		Howales
of	ng Phys fter this neral di	atlon: To	1 Yes 27. Manns of Death 1 ZNatural 5 Pending 2 Accident investigation	28a. Date o		28b. Time of Injury		Bc. Injury Work	4 🗆 Nur	2	ne 5 Reside 8d. Describe ho			HUTIVE
Division	- 9	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ed 200. Place	of Injury - At ho ng, etc. (Specify	me, farm, stre	eet, factory,	office		2	8f. Location (Str City or Town		er or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funerel Direction Completely filled in the compl	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the xeminer: On the ba and mann	isis of examinat	wledge, death ion and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, death	place, a	nd due to the ca od at the time, da	use(s) and mai ate and place, a	nner as s and due to	tated. the cause(s)
	To t To t	≊	29b. Signature and title of certifier	Minal	MI	7	29c.	License	number	2	29	ed. Date signed	(Month,	Day, Year)
	9		30. Name and address of person y	ho completed cause	e of death (Item	23a) (Type	Print)	000	TH	2/6	Bath	mon	1	1/2/2/8
	sta Registr		31. Date filed (Month, Day, Year)	2004 32. Re	gistrar's Signat	ture &	So	als	1/4		V////	The state of the s		4, - + ×

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 l Certificate of Death

	3	5	6		L
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3. Time of Death

Reg. No.

2. Date of Death

	Physicia /Medic		Charles	Lee		McInty	re	OMMODI	er 30	, 2004	1454Р. м
	Examin		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c.	County of Deati	1
			7503 Surratts I	Road		Clinton			P	rince G	eorges
	Funeral Director		5. Social Security Number 243–23–2764	5. Sex 7. Age (In yrs. I 1 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)		nplace (State or Foreign untry) d
		l	Usual Residence of Decedent					100			
	ylan		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mar Mar	to	MD Princ	ce Georges	Su	itland					1 ☐ Yes 2X No
	r 288	irec	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	untry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Items 23e or 28a-f show any injury or other treumatic event, I'm Moulcal Examiliation at the motified at once.	Funeral Director	4706 Hudson A	Ave #A		207	746			U.S.A.	
	death ms 2	Jer	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.1	Was Decedent of H	ispanic Origin? (Sp	pecify Yes or N	0-	14. Race - Ame	
9	after or Ite	Ē	1 Never Married 2 Marrie			1 ☐ Yes 2 🛣 No	Specify:	7 (104), 010.7		Sanaihe	
Š	ours a	by	3 ☐ Widowed 4XXX ivorced	Year or Dates:		1 1 es 2 2 1 NO	Spacity.			B1	ack
21215-0036	72 hc	Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occup-	ation during most of work	kina	16b. Ki	nd of Business/	ndustry
2	thin en .	ple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired					
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pu	al Hy al Hy oth	Be (17. Father's Name (First, Middle, L				18. Mother's Nam				
Maryland	uld b Ment wrkec	2	C. Walter Che	erry			Mae Ell		_		
a	and l		19a. Informant's Name/Relationsh								^(ip Code) 27704
	alth 27 i		Mae Ellen McIn	ntyre Jones-Mo	ther	1442 Ne	ew Castl	Le Roa	d D-	2, Dur	ham, NC
<u>5</u>	s 1 s of He item		20a. Method ol Disposition	20b. P	lace of Dispo	sition (Name of matory or other place	(e)	Date	20c. Lo	cation - City or	Town, State
Ë	Page ent c nt: If ry or		XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ∐Removal from State ecify)	Glen	matory or other place n View rial Par	ck 11/5	5/04	Dur	ham, N	IC
Baltimore,	orte		21. Signature of Funeral Service L			Name and Address					
ä	permii Depar Impor any ir		MINIALA	(STUMH	4	300 Waba	ash Ave	Balt	imor	e. Md	21215
			23a. Part1. Enter the disease, or o	complications that caused the death				-			Approximate Interval Between
			shock, or heart failure. List of		. 100				- 6		Onset and Death
>	Physician / /Medical		disease or condition resulting in death)	*CARDIOMEGDLY		aster we	THE MITTERS	UVDEV	E 112	उरता ५	
	Examiner			Due to (or as a consequ	uence or):						
		-	Sequentially list conditions, if any, leading to immediate	bbue to (or as a consequ	uence of):						
	bed sit	nin	cause. Enter Underlying Cause (Disease or injury	()	,						
	and and	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence ol):						
09	be e. ician buria										
68760,	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	sician/Medical		d							
9 ×	entifii ding l	/Me	IF FEMALE:	23c. If yes, outcome of pregna	incv					22d Date of dali	1001
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta	I death 3	Ectopic pregnancy	/			23d. Date of deli Month	Day Year
& <u>~</u>	the a		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d	eam 5L	Other (specify)					
Ρ.	d by	by Phy		ns contributing to death but not resi	ulting in the u	nderwing cause av	ren in Part I	23e. Did	tobacco u	ise contribute to	the cause of death?
Ś	res ti		artii. Othor significant condition	To continuous to document to the continuous	annig ii i iio a	riddiny ing daddo gir				. /	obably 4 Unknown
orc	w requir been si should	ted								7	
Records,	aw ls b	ple						24a. Wa:	psy	prior to	topsy findings available completion of cause of
	The taste has page	Completed						1 Yes	ormed? 2 ☐ No	death?	2 🗆 No
of Vital	sicien: Th certificate rector, pag	Bec	25. Was case referred to medical				26. Place of Dea	th (Check only	one)		
>	Physicien: this certific ral director,	To E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Oth	er: 4 🗋 Nursing H	ome 5 Res	idence (6 x Other (Spec	ity) (scene)
0			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at k?	28d. Describe	how injur	y occurred	
Ö	Attending r death.	atio	1 Natural 5 Pending 2 Accident investig				Yes 2 □ No				
Division	Atte	ifi	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Place of Injury - At he building, etc. (Specif	ome, larm, st	reet, factory, office			(Street an		ral Route Number,
Ö	s afte	Certification	Tomose	building, etc. (apasin	,,				, =	,	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical (g Physician: To the best of my kno Examiner: On the basis of examina and manner stated.							
	thin 2 the mple	Med	29b. Signature and title of certifier	and mainer stated.		29c. Licens	se number		29d. Dat	te signed (Monti	n, Day, Year)
	To To		255. Significand and title of Certifier	Dr. 18.00	Th. A.	O.C.M				ber 31,	
	\wedge		munic	Time your	M						
	7)		30. Name and address of person	who completed cause of death (Item	n 23a) (Type,	Print) 111 P	enn Stree	et, Bal	timor	e, Mary	land 21201
			MARGIZENTS	13. KURELL							

31. Date liled (Month, Day, Year) NOV 1 0 2004

DHMH 17 Rev 1/2001

State

Registrar

park

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 25, 27, 28a-f per meo 837 11-9 04

State of Maryland Department of Health and Mental Hygiere 0

1 - State Registrar AMEND ITEM #5 PER FH C837 11 Pestificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 22, Murphy Ju₁y 2004 11:20 a^M Grace /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 400 Symphony Circle, apt. 313 Hunt Valley Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🂢 F 82 219-01-4772 July 3, 1922 Director Maryland Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in then "neturel", or itams 23a or 28a-f show the McCral Examiner must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director Maryland Baltimore Hunt Valley 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 400 Symphony Circle, apt. 313 21030 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) iled within 72 hours after 1 Never Married 2 Married 2 ₹ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 08 n/a Homemaker Own Home of Health and Mental Hygis fitem 27 Is marked other I r other treumatic event, III other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental F int: If item 27 Is marked of Lombardi Eufrasina DiGiacomo 2 Carlo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45 North Crescent, Maplewood, NJ Mary Meyers/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 24, 2004 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 8 Department of Importent: If eny injury or once. 1 Signature of Fureral Service Liberto

Bryan W. Clary Dulaney Valley Mem. Gardens Timonium, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or complica shock, or hear failure. List only one Approximate Interval Between Onset and Death ons tha ause of Immediate (ause Final disease or condition resulting in death) Rebrovascular **Physician** d /Medical Examiner peripheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit ignetes Due to (or as a consequence of EXAMINER DETTING APPROVED BY MEDIC Physician/Medical the Box (IF FEMALE use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No for 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Catrony No nace maker, permanent 1 Tyes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? ner has page 2 autopsy 1 Yes 2 No certificate 25. Was case referred to medical examiner? Rece 1 Yes 2 No Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: Yes ZXIVO 1 Inpatient 2 ER/Outpatient 3 DOA 2 this o 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Division Hospital or Attending 5 Pending investigation Natural Subject fell death. 2x Accident 6-30-04 unknown M 1 Yes 2 No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town State) determined 4 T Homicide n 24 hours at house Glen Rock, PA 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal (Check only one) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 20 2044296 July 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marian Rutigliano, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State parks NOV 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiepen 0 [For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Morrow 9:30 AM Jovem be 8 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arunde Glen Burnie HOSPITAL North Arunde If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 11/20/1977 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2XXX 26 MARYLAND Director 213-06-1178 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, ite Medical Examinar maratice notified at 1 Tes 2000 Director MD ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 639 RIDGEFIELD COURT 21061 USA Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ NO If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status MXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 🗓 No Specify: WHITE Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene NEVER WORKED NEVER WORKED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental snt: If Itam 27 is marked o JANE BOWEN JAMES KNIGHT MORROW, SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JANE MORROW - MOTHER 639 RIDGEFIELD COURT, GLEN BURNIE, MD 21061 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of I Importent: If Its any injury or o once. 1 ☐ Burial 2 XXremation 3 ☐ Removal from State BAYVIEW CREMATORY 11/9/2004 BALTIMORE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fune par Service Licensee FINK FUNERAL HOME, PA KELLY GREGORY FINK #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner i been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed na Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 210 No 3 Probably 4 Unknown ulmen 1 🗌 Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Q autopsy perform page 2**/2** No 2□ No certificate 1 Tyes or Attanding Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: After 1 Natural 2 Accident 5 Pending 2 □No death. 1 Tes investigation the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certific D0032744 3 Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr North Arundel HOUDHOLCH 31. Date filed (Month, D 9 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 8, 2004 11:30 AM ANGELO P. MORONE /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNAPOLIS ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 11/2/1916" Months Days **27**M 2□ F 88 PATERSON, NJ 151-05-5606 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ir than "natural", or itams 23a or 28a-f show the Medical Examinal must be notified at 1 ☐ Yes 2 XX ANNE ARUNDEL CROFTON Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21114 U.S.A. 1640 FALLOWFIELD COURT Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No 1 Never Married 2 Married Specify: WHITE 1 Yes XXNo Baltimore, Maryland 21215-0036 Specify: Ď 3XXWidowed 4 ☐ Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) INSTRUMENT MAKER MANUFACTURING 12 of Health and Mental Hyg if Item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental JOHN MORONE MARIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once. 1315 PLEASANT MEADOW ROAD, CROFTON, MD 21114 JOHN J. MORONE - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3XXRemoval from State 11/9/2004 SHOOK FUNERAL HOME CLIFTON, NEW JERSEY * 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND MORTUARY SUPPORT 21. Signature of Funeral Service Liven 22. Name and Address of Facility KELLY CREGORY 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 FINK #M01148 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of): Examine burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the as esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? for 5 Other (specify) 4 Pregnant at time of death ned by the a 1 ☐ Yes 2 ☐ No o. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, sign d be 1 Yes 2 No 3 Probably 4 Nhknown peeu Oslo 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rector, page 2 perform 1 ☐ Yes 2 ☐ No 200 No Vital Physician: 26. Place of Death (Check only one, director 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA 2 2 00 of this After thi Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 🗌 Yes 2 No within 24 hours after upage...
To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö to Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one) 29d. Date sidned (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Amend item/Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () () 35618 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** David R. Mullinix 2004 10:30a November 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death **Examiner** Frederick Kline_Hospice House Mt. Airy If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □XM 2 □ F Yrs. 10, Director Oct. 1932 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If tiem 27 is marked other then "neturel", or items 23a or 28a-f show 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits r is marked other then "neturel", or items 23a or 28a-f show treumatic event. Its Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Howard Mt. Airy 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 21771 2287 Mullinix Mill Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lottie F. Watkins 2 J. Herbert Mullinix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health item 27 i Kathryn A. Mullinix/ Wife 2287 Mullinix Mill Road, Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If eny injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) Howard Chapel Cemetery 11/10/04 Mt. Airy, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician Mytastatic disease or condition resulting in death) 17 + GRUMA yers /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispass or injury) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai the as IF FEMALE: 23c. Il yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? ō Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown s been signed by the should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ** No page 2 certificate 18 No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2XNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DDA è 28a. Date of Injury (Month, Day Year) After the 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide pellil the Hospital within 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/8/04 073404 30. Name and address of person #10 completed cause of death (Item 23a) (Type, Print) Med Sharfma 10753 (916 Limerille W. Hinn Cel #1415 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 5, 2004 Physician Lloyd Welford Marders 5:40 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death Examiner Charles Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 3, 1 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1√2 M 2□F Days Hours Min. 229-40-7522 72 Yrs 1932 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a, State 10b. County 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Charles Newburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20664 United States 9975 Dothian Place Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Korea Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Korea Completed by 3 ☐ Widowed 4 ☐ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Mechanic Automotive 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill iment of Heelth and Mental H tant: If item 27 is marked other. Margaret Minter Wilbert Wilber Marders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9975 Dothian Place, Newburg, Maryland 20664 Elizabeth Ann Marders/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or oti 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 10, Silver Spring, Maryland • 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licer 7MOO689 Part I Shter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock object failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by PARKINSON'S DISENSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? DYSPHAGIA 2 100 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending efter death. Director: A 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occuπed at the time, date and place, and due to the cause(s) and manner as stated. Medicai within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier

DY s

State 31. Date filed (Month, Day, Year)
Registrar NOV 0 9 2004

+ UCTOW

32. Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

& Sparker

November 9, 2004

CHARLOTTE HALL, MD

State of Maryland / Department of Health and Mental Hygiene 00 1 35620 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** Roy Franklin McGrady NOVEMBER 4, 11:30 P ^M 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death Examiner CROFTON CONVALESCENT & REHAB CENTER CROFTON ANNE ARUNDEL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sep. 16, 1923 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F Virginia 81 223-22-7643 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10b. County 10a. State r then "naturel", or Items 23a or 28a-f show the Medical Examples must be multied at 1 Yes 2 □ No Prince Georges Bowie Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 12407 Keynote Lane 20715 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No I' Yes, Give Year or Dates: '43-'45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Machinist Fabrication 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If item 27 is marked ofth any ijury or other traumatic event, 9DR8: 17. Father's Name (First, Middle, Last) Be Nannie Noble Coffey Wayne McGrady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3800 Enfield Chase Court Bowie, Maryland 20716 Charles McGrady/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 11/10/2004 Waldorf, Maryland Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 year Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 donknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy 2 X No 1 ☐ Yes 2 ☐ No this certificete 1∏ Yes or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩o 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours t 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 35848 cause of death (Item 23a) (Type, Print) Honardle 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiepe [] [] 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year William Miller 2:20 PM 05 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN NA HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1**⊠**M 2□F 218-94-0540 39 Director Vrs 10-28-65 Md Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Itams 23e or 28e-f show traumatic avant, Ins Madical Examiner must be notified at 10d. Inside City Limits Director Md. Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3721 Keene Ave. Funeral 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. is marked other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: 3 Widowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Packer 12th grade Super Fresh 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Annis Miller Reba 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If itam 27 is a Reba Miller Mother 824 Kevin Rd., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ō permit. Page Department of Important: If any Injury or * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 11-11-04 Lansdowne, Md. 21. Signature Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave 20a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Septic Immediate Cause (Final Enysician Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PANCREATITIS NECROTISENG Sequentially list conditions, Examiner Oua to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL FAILURE 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Pinpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funarel Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signatule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Grassan KES 000 11/05/ 04 30. Name and a sess of person who completed cause of death (Item 23a) (Type, Print) HINGORANI OCH RAVEN BLVD. BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 00 1 35622 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Movember 09, 2004 **Physician** James V. Noonan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 7, 19 Birthplace (State or Foreign Country) **Funeral** 1**∅** M 2□ F Days Hours Months Yrs. Director 213-09-2664 91 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location worle 10d. Inside City Limits the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland N/ABaltimore 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 3717 Erdman Avenue 21213 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Almor Polces: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1 9 4 1 - 1 9 4 5 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: þ Specify: 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Clerk Post Office Ith and Mental Hygie 27 Is marked other! r treumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H tent: If item 27 Is marked oth Daniel Noonan Katherine Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Hardy (Daughter) 5507 Pioneer Drive, Baltimore, Md. 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. *4 Donation 5 DOther (Specify) Encombment Parkwood Cemetery 11/12/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes stikame Lane, Baltimore, Maryland 21213 3331 Brehms 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pneumonia davs /Medical Examiner eme Tia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as,a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed QUICON Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte I be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Ö 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes Division of Vital To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No npatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospitel within 24 hours a To the Funerel C Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 30. Name and address of person who completed cause of death (Item 2, a) (Type, Print) Kats union Memorial HO 31. Date filed (Month, Day, Year) 32. Harstrar's Signature State NOV 1 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygien ? 35623 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Eleonora Steger Oeltjen November 8, 2004 10:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | Dec. 23, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ☑ F 213-46-8334 91 Yrs. 1912 Nebraska Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1⊈ Yes 2 No Directo Maryland | Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9624 Carriage Road 20895 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2X No ģ 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other It any injury or other traumatic event, Ita ODG. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Steger Sophie Kuemmerer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick J. Oeltjen/ Son 1904 S. Fallsmead Way, Potomac, MD 20854 competery crematory of other place)
Tarkiawii Memorial Nov. 11, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal from State Rockville, 1 4 ☐ Donation 5 ☐ Other (Specify) 2004 Park Maryland 21. Signature of Funeral Service Lio Insee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M00689 23a. Part 1 Inher the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 waks UROSEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner sician and e burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical phys the t anding I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ **(**0)o 4 Tursing Home 5 Residence 6 Other (Specify) After th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 24 hours after death.

Per Funeral Director: / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 2 D5006/2 November 8, 2004 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel G. Maller, M.D., 3305 N. Leisure World Blvd., Silver Spring, Maryland 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

NOV 0 9 2004

State of Maryland / Department of Health and Mental Hygiene 35624 Registramend Frem #7&8 PER FH C837 15 15 164 of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2007 1579 M O'BRIEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hypthsville Cras by ROAd 18/0 6 8. Date of Birth -02-1938 Birthplace (State or Foreign (Month, Day, Year) Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days Min Hours 1 □ M 2 X F 577-72-7973 JAMAICA Director 70 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show Examiner thust be notified at 1 X Yes 2 ☐ No PRINCE GEORGES HYATTSVILLE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1810 CROSBY ROAD 20783 Items 23a U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned 21215-0036 naturel', or 1 ☐ Yes X□ No Specify by 3 ☐ Widowed 4 ☑ Divorced BLACK Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE PROVIDENCE HOSPITAL 4th Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event RRE. Be JOHN DWYER CHRISTIANA MAXWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL O'BRIEN/DAUGHTER P.O. BOX 670652 MARIETTA, GA 30066 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND NAT. PK. 11-13-04 LAUREL, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME. INC. 7601 SANDY SPRING RD. LAUREL, MD 20707 Tem 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive Hant Dis en Artwoosderetic **Physician** /Medical Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. attending physicien by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 4☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 □ Yes 2 □ No. 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After ! 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 24 hours after of Funeral Direct 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2. To the F ţ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who a mpleted cause of death (Item 23a) (Type, Print) SALVADOY SUVESTA 3001 1500 n) tal Drive 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:10 PM ROVENZA 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** CARROL 4 Kesville Care ONTHHULL If Under Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 📆 🕱 BROOKLYN, NY 89 067-14-0942 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County or 28a-f show r than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 1 Yes XX No BALTIMORE CATONSVILLE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 6420 FREDERICK ROAD Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc within 72 hours after 1 Never Married 2 Married 1 Yes XX No WHITE Maryland 21215-0036 Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If itam 27 Ia marked otl ROSELLA DEATON SALVATORE MEGNA 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHANIE PROVENZA SKIFFINGTON 52 HOLMHURST AVENUE, CATONSVILLE, MD 21228 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 5 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. BALTIMORE, MD 11/8/2004 NEW CATHEDRAL CEM. * 4 □ Donation 5 □ Other (Specify) 21. Signatur / Puneral Service Lic-22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 KELLY GREGORY FINK #M01148 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Examine The law requires that the death certificate be executed inding physician and use as the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year for Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 2 No certificate 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Diractor: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who,

NOV 0 9 2004

31. Date filed (Month, Day, Year)

Stoner

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

	4	For State	State of Ma	ryland	/ Depa	rtment of H	lealth a	and Men		jie <u>p</u> e	4 35	5626
Physicia		Registrar 1. Decedent's Name (First, Middle,		onr					Date of Dea Month	th Day	Year 3.	Time of Death
/Medic Examin	al -	la. Facility Name (If not institution,	give street and number)		,	4b. City, Town, or			mo	4c. County	•	1 =
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with the a or 2	Dire	10e. Street and Number 1510 Mosher St.				21217	7				USA	
death ms 23	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	13.	Was Decedent of H If Yes, specify Cuba		igin? (Specify	Yes or No-	14. Race Blace	e - American In ck, White, etc.	ndian,
IIIQ X IX 13-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28e-f show event, the Medical Examinar must be notitied at	by Fui	1 Never Married 2 Marrie 3 Widowed 4 Divorced	1 Tes 2 N If Yes, Give X Year or Dates:	lo		1□Yes 2□No	Specify:			Specify	Blac	ck
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2 0 = 0		19a. Informant's Name/Relationsh Maria Joiner	Step-Daugh	ter		Locust I						
re, IV		20a. Method of Disposition 1 Wental 2 Cremation		20b. Pla	ace of Dispo	osition (Name of matory or other plan	сө)	Date		20c. Location -		State
baltimore permit. Pages 1 Department of H Important: If ite any injury or otl		`4 ☐Donation 5 ☐ Other (Sp	pecify)	Mt.		el Cem. 2. Name and Addre	i	11-10-0		Dundal imore,		1202
Departition of the policy of t		21. Signature of Euneral Service L	1/2			March F	.H. E	ast	1101	E. Nort		
RESERVE OF		23a. art1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each lim	the death	. Do not an	e mode of dyin	ng, such as	s cardiac or re	spiratory a	rest,	Inte	proximate erval Between iset and Death
Physician	П	Immediate Cause (Final disease or condition	-a. ME 1+	ASIA	4716	DISE	ASE					
/Medical Examiner		resulting in death)	Due to (or as			ef 5	Tons	teH.				
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Records, P.O. Box 6870 The law requires that the death certificate tate has been signed by the eltending physionage 2 should be detached for use as the b	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 4 Pregnant at	2 Fetal	death 3	□Ectopic pregnand □ Other (specify) _	у				onth Day	y Year
IS, P.O. I	Phys	9 ☐ Unknown Part II. Other significant condition		out not resu	ulting in the	underlying cause gr	ven in Part	l.	23e. Did t	obacco use con	tribute to the c	ause of death?
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Records, he faw requires t e has been signe	Completed								24a. Was auto	psy	Were autopsy prior to comple death?	findings available etion of cause of
	Com							- 4 D 11 - 1	1 ☐ Yes	2DNo	1 ☐ Yes 2 ☐] No
of Vital F Physician: Th ribis certificate ral director, pag	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hoonital:	ent 2 🗆	ER/Outpatie	ent 3 DOA Ot	han	ursing Home		one dence 6 □Oth	her (Specify)	
g Physical this seral d	n: To	27. Manner of Death	28a. Date of Inju	ury	28b. Time Injury	of 28c. Inju			d. Describe	how injury occur	rred	
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lospite t hours unerel	edical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis of and manner si	of examina	wiedge, dea tion and/or i	ith occurred at the t nvestigation, in my	time, date a opinion, de	and place, and eath occurred	due to the at the time,	cause(s) and m date and place,	anner as state , and due to the	d. e cause(s)
To the h within 24 To the f complete	Med	29b. Signature and title of certifie	er o			29c. Licer	nse numbe	r		29d. Date signe	ed (Month, Day	
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/		30. Name and address of person		death (Item	Dol 8		FF	BA	Timo	në M	7 2	1517
y S	tate	31. Date filed (Mack Day, Year	2004	trar's Signa		Sport		1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death QUINN JUNE Ε. 2:30 A M 07 -2004 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death OAK CREST VILLAGE CARE CENTER PARKVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Months Days Hours 1 □ M X2X F 216-01-4377 87 Yrs 06-04-1917 BALTIMORE Usual Residence of Decedent 10c, City, Town or Location 10a State 10h Count 10d. Inside City Limits 1 □ Yes 🏋 No MD. BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8834 WALTHER BOULEVARD 21234 U. S. A. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: WHITE Specify: XX(Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done do life. DO NOT use retired) during most of working BLUE CROSS BLUE Elementary/Secondary (0-12) College (1-4or 5+) CLERK SHIELD OF MARYLAND YEARS 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **ERNEST** ELWELL HELEN ROBERT REHBEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) GARY QUINN 1700 SOUTH EAST LADD AVENUE, PORTLAND, OREGON, 97214 Μ. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 11-10-2004 TIMONIUM, MARYLAND DULANEY VALLEY M.G. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. R. H. Kui TOWSON,MD.21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0515 disease or condition resulting in death) SP da Due to (or as a consequence of): 5 12-98 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): SC V 0 that initiated events resulting in death) Last Due to (or as a consequence of) tensun IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ He 3 ☐ Probably 4 ☐ Unknown an Kinson 1 1) 1 50 6 50 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ¥No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, P.O. Box 68760, plate or Attending Physicien: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

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permit, Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event size.

Physician

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Certification:

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treumatic event, the Medical Examiner must be notified at

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

Be Completed by Funeral Director

Division of Vital

To the Hospital or Attending Physicien: The Within 24 hours eiter death.

To the Funerel Director: After this certificate completely filled in by the funeral director, pa

State Registrar

MOM a a asis

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



au siere mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Briging parks

8200 CA THEN ALVO WAR TUNGEMO2133)

State of Maryland / Department of Health and Mental Hygiene 35628 For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Reising Month Year **Physician** Pau E. Nov 2:15 PM 2004 8 /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens at Riderwood Village Silver Spring Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 77 Yrs. 220-12-2756 Director Nov.9, 1926 Washington, D.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Montgomery Silver Spring "natural", or items 23a or 28a-f sh pical Examiner must be notified 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3128 Gracefield Road, #412 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2X Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 7 is marked other than "natu traumatic event, In a Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Certified Public Accountant N.A.S.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Albert Reising Albra Emerson 7 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances L. Reising -wife 3128 Gracefield Road, #412 Silver Spring,Md.20904 item 27 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gate of Heaven Cemetery 11/12/2004 Silver Spring, Marylan Department of h Important: If ite any injury or of once. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Emeral Sprvide Licence 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspuration **Physician** 2 days disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): -burial-1 physician sthe burial Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown Š signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Laknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has l autopsy performed? certificate ha 2 46 1 Yes Division of Vital Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Sing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending death. 1 Yes 2 No investigation after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours at the Funeral D mpletely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number tushumana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN PUTHUMANA, 3110 GrACEFIELD ROAD, SILVERSPRING, MD 20904 **1**() State 0 2004 Registrar

Unpend Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Amend item1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** Lorenzo Melendez Rivera 20, October 2004 7:51 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | 08/10/1967 N/A Johns Hopkins Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 15 M 2□ F Yrs. Mexico N/A 37 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo N/A Baltimore Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21224 3428 E. Lombard Street Mexico Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1- Never Married 2 ☐ Married Syes 2□No Specify: Mexican Baltimore, Maryland 21215-0036 "natural', or Specify: Hispanic þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed withln 72 h and Menta! Hygiene. 7 Is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) Concrete Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Chistina Rivera Rosa Faustino Melendez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an Item 27 is i 3428 E. Lombard Street Baltimore, Md 21224 Luis Rivera Sosa 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ■ Removal from State San Judas Padeo 11/09/04 Mexico Tepetlix P.A. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wise Funeral Services P.A. 700 S. Beechfield Ave Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a Acute Ethanol Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or n.jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Box 68760 death certificate be Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ₩07es 2 □ No 24a. Was an autopsy 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2X EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∑Yes 2 No this 28a. Date of Injury (Mo. In, Day Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Found 7:23 p 1 Natural 5 Pending death. 1 ☐ Yes 2 ▼No investigation 2 Accident Unknown after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 2300 Blk. E. Baltimore St. filled in by 4 | Homicide To the Hospital within 24 hours at To the Funeral D Found in park Raltimore Maryland 29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie, 29c. License number My October 21, 2004 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPPLEMS 111 Penn Street, Baltimore, Maryland 21201 31. Date filled (Month, Day, Year) 32. Registrar's Signature State NOV 0 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygien@ 35630 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** NOV. 2004 EDNA LOIS RATHGEBER 3 12:01AMM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis Eldercare-Franklin Woods Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔽 F Nov. 29, 1910 Maryland Director 214-40-7552 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Baltimore City Baltimore City 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 909 South East Avenue 21224 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo þ Specify: White 3℃Widowed 4 □ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Board than Elementary/Secondary (0-12) College (1-4or 5+) Secretary of Education N/A other t permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If Item 27 is marked other eny injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lena Schmidt Michael Keiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Fuller Avenue Baltimore, Ruth Enders (Daughter) Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 11~8~2004 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home Lassahn Baltimore. Md. 21236 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D completely filled it To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number W11150 30 ame and address of person who completed cause of death (Item 23a) (Type, Print) 441 S. ELL0000 ADE BALTO, MD 21224 IORRES MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of Mary		artment of He rtificate of D			2004	35631		
	Physici /Medic		1. Decedent's Name (First, Middle, Li Barbara	J.	Ric	S		2. Date of Death Month	Day DY 200	3. Time of Death		
	Examin		4a. Facility Name (If not institution, gi Stella Maris Me			4b. City, Town, or Le Balt	ocation of Death		4c. County of Death	1		
	Funeral Director			Sex 1 □ M 2√2 F 7. Age (In 56	yrs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 6-24-48	(ea <i>r</i>) 9. Birth	nplace (State or Foreign intry) Md.		
	yland how		Usual Residence of Decedent 10a. State 10b. County		:. City, Town or Lo					10d. Inside City Limits		
	the Mar 28e-f s	Director	Md. 10e. Street and Number	NA	Baltin	nore		100	. Citizen of What Co	1 X Yes 2 □ No		
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036	be filed within 72 hours after death with the Maryland hat Hygiene. ad other then "neturel", or Items 23a or 28e-f show event, I're Madical Erarifrat routile and lifed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3√□ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of Hisp f Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White Specify: B1			
15-0	in 72 ho n "netu	Completed	15. Decedent's E (Specify only highest gi	ade completed)	(Give	dent's Usual Occupation kind of work done dur DO NOT use retired)		ng 16	b. Kind of Business/l	ndustry		
Maryland 21215-0036	e filed within al Hygiene. other then vent, the Ma		Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Las	College (1-4or 5+)	Dia	sabled	8 Mother's Name	(First, Middle, Ma	NA			
ylan	should be ind Mental in marked o	To Be	George	М.	Johnson		Rebecc	a	Robinson			
	nd 2 shu alth and 27 is m ir treum		19a. Informant's Name/Relationship Gary Johnson	(Type, Print)		ng Address <i>(Str</i> eet a <i>nd</i> J Mistywoo				p Code) 21093		
altimore,	ages 1 ant of Heam		20a. Method of Disposition 1 Durial 2 Commation 3	Removal from State	b. Place of Dispo	sition (Name of matory or other place)		ate 20	c. Location - City or 1			
altin	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic erone.		* 4 □ Donation 5 □ Other (Speci 21. Signature of Euneral Service Lice	Balti	Baltimore, more, Md.	21202						
<u>В</u>	202 8 9		23a. Part1. Enter the disease, or con shock, or heart failure. List only		North Ave.	Approximate Interval Between						
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	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	sequence of):							
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a con	sequence of):							
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.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent prégnant in the past 12 pronths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year		
rds, P	The law requires that tte has been signed b page 2 should be deta	by	Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying cause given i	in Part I.	23e. Did tobac	co use contribute to	he cause of death?		
Il Records,	10	Completed						24a. Was an autopsy performed	d? prior to co	opsy findings available impletion of cause of 2 No		
Vital	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	Other	6. Place of Death		e 6 Ø Other (Speci	m hospice		
on of	ding Phys h. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury at Work?		8d. Describe how		" respice		
Division	or Attend after death Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	e One Place of Injury				8f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,		
	To the Hospitel or Attending Physicien: which 24 hours after death of the Funerel Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	nysician: To the best of my miner: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the time, restigation, in my opini	date and place, a ion, death occurre	nd due to the caus d at the time, date	e(s) and manner as s and place, and due t	stated. the cause(s)		
•	To the vithin To the comp	M	29b. Signature and title of certifier	V W)		29c. License ni	umber	29d.	Date signed (Month,			
	3		30. Name and address of person who	dempleted cause of death (Item 23a) (Type, F	Print)	eldino		77	72		
	Sta Registra	_	31. Date filed (Month, Pay Year)	2004 32. Registrar's S	ignature	Spork		- WUX				

State of Maryland / Department of Health and Mental Hygie 🎾 🛭 🗓 35632 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** CLARA J. ROGERS NOV. 8,2004 10:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3908 HUDSON STREET BALTIMORE N/A 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign 1 □ M 2X F 219-03-3395 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic avant, the Medical Examinar must be notified at 1XYes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3908 HUDSON STREET 21224 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. is marked othar than "natural", or Ital 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 1 Ó HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ADAM GERLACH MARY SCHIMMEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i KATHLEEN KIST/DAUGHTER 3113 ROSSPOINT ROAD, LAUREL, DELAWARE 19956 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of Inportant: If its
any injury or of 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 11/11/04 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 22 Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 21. Signature of Funeral Service Licensee CONKLING STREET, BALTO, MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleratic Physician Cardio Vascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Hupertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed Cerebrovaecular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate 2 No 2 □ No 1 ☐ Yes Division of Vital 1 Tyes the Hospital or Attanding Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Salahuddin Dalian DZ0252 108 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALIAH SALAHUDDIN, M.D. #20 CROSSROADS DRIVE, SUITE 101, OWINGS MILLS, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene [] []

1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year RUBINSTEIN 0:30 AM November 7 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SINAL BALTIMORE HOSPITAL OF BALTIMOTE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 POLAND **Funeral** Days 1 € M 2 □ F Months Hours Min. 82 216-18-0358 Director Usual Residence of Decedent Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f shov Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Madical Examinar must be notified #1 Director 1 Yes 2 □ No MD N/A BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6408 ELRAY DRIVE #C 21209 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER MEN'S CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL RUBINSTEIN ္ပ ROSE ZUKENMACHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an Item 27 is 6408 ELRAY DRIVE #C - BALTIMORE, MD 21209 BESSIE RUBINSTEIN / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages Depertment of Important: If It any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 11/09/2004 RANDALLSTOWN, MD 21. Signature of Funeral Service Lîcensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ASCVO Complication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by LIMPHOCKTIC (21/kemiA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ N Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 00 Res -000 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hurles Simai HOSPITAL UF MAITINGIE Griffith 00 31. Date filed (Month, Day, Year) 132. Registrar's Signature State

Registrar

NOV 1 0 2004

		1- For Amend Item	23a per Dr	aryland/Di	partment of H PTD/04dhb Pertificate of	lealth and Mo Death	ental Hygiene Reg. No	2004	35634
Physi /Me	ician dical	1. Decedent's Name (First, Middle, La MARLEEN	ast)	STEU	ART		2. Date of Death Month Da		3. Time of Death 11. 24 A M
Exam	niner	5. Social Security Number 6.	d County Gener	al Hospital e (In yrs. last birthe			umbia 8. Date of Birth (Month, Day, Year)	9. Birtho	Oward place (State or Foreign
Directo	or	Usual Residence of Decedent	1 □ M 2 □ F	59 Yr	s.		October 21, 1	945 Balti	imore, Maryland
e Maryla e-fshov	ctor		-loward	10c. City, Town o		Ellicott City			10d. Inside City Limits 1 ☐ Yes 2 ☐ No X
h with the 13a or 28 11 be no	ai Director	10e. Street and Number 3000 North Ridge Ro	ad		10f. Zip Code	20143	10g. Cit	tizen of What Cour	
)36 urs after deat it', or items 2	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Qvorced	12. Was Decedent II Armed Forces? 1	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		ify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify:	can Indian,
IOFE, Maryland 21215-9036 ges 1 and 2 should be filled within 72 hours after death with the Maryland to it Health and Mental Hygiene. If tiem 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation	(6	ecedent's Usual Occupa Give kind of work done of fe. DO NOT use retired	during most of workin f)	g 16b. K	ind of Business/In	
nd 21 be filed wi tal Hygien d other th	Be Co	17. Father's Name (First, Middle, Las	t) 4t		ho	memaker 18. Mother's Name	(First, Middle, Maiden	Sumame)	
Maryland 2121 d 2 should be filed within th and Mental Hygiene. ?? Is merked other than traumatic event, the Me	To	Theodore 19a. Informant's Name/Relationship	R. Greenberg (Type, Print)	19b. N	failing Address (Street a	and Number or Rural		ances Linde or Town, State, Zip	
ore, Mass tand 2 of Health a fitem 27 la		Ms. Heather McKeel 20a. Method of Disposition 1 □Burial 2 □ Cremation 3 [20b. Place of D	829 Weatherly isposition (Name of crematory or other place	Da	ite Zoc. Lo	922 ocation - City or To	own, State
IL Pa t. Pa rtmer rtent:	once.	'4 ☐ Ponation 5 ☐ Other (Special Service Logical Service Logi	ty/	Meadow	ridge Memorial I 22. Name and Addres	ss of Facility	3/2004	Elkridge,	Maryland
o gge	4	23a/Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused one cause on each lin	the death. Do not le.	enter the mode of dyin	Funeral Home, old Columbia F g, such as cardiac or	Ike Ellicott City	, MD 21043	Approximate Interval Between Onset and Death
Physicia /Medica Examine	ıf 🔣	Immediate Cause (Final isease or condition resulting in death)	Due to (or as a	a consequence of)	40(adial	-1no	nclas		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Old Due to (or as a	Cerebro a consequence of	vascular A	ccident		1	
58 / 50, ficate be executed physician and is the burial-fransit	edicai Exa	that initiated events resulting in death) Last	d.	a consequence of)	e vertula	Acced	ent.		
O. BOX to the death certiff the attending the death use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ery Day Year
COTGS, P., w requires that it been signed by	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in th	ne underlying cause give	en in Part I.	23e. Did tobacco u 1 ☐ Yes 2		
	Completed						24a. Was an autopsy performed?	prior to cor death?	psy findings available mpletion of cause of
VITZ sician s certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpa	atient 3 DOA Othe	26. Place of Death or: 4 □ Nursing Hom	(Check only one) e 5 Residence	6 □Other (Specifi	v)
DIVISION OF t or Attending Phy after death. Director: After this d in by the funeral d		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Tim	e of 28c. Injury	at 28	3d. Describe how injur		,
DIVISION BLANCE STATEMENT	Certification:	3 ☐ Suicide 6 ☐ Could not to determine of the determine			, street, factory, office	28	of. Location (Street and City or Town, State	d Number or Rura)	l Route Number,
UNISION OT VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	29a. Certifier Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/o	r investigation, in my or	oinion, death occurred	at the time, date and	place, and due to	the cause(s)
To the to the complex	Σ	29b. Signature and title of certifier			29c. License	number	29d. Dat	te signed (Month, I	30 2004
12		30, Name and address of person who	completed cause of de	201 - (0°	pe, Print) Back	River 1	veck Ro	ad Ball	Day, Year) 30 2004 my muylu my 2) 221
S Regi:	tate strar	31. Date filed (Month, Day, Year) NOV 0 9 2004	32. Registra	r's Signatus	Sports				

State of Maryland / Department of Health and Mental Hygien 2004 35

		•	For State Registrar		,	Cer	tificate of L	Death		Reg. I	Z U U 4	33633		
Ľ.			Decedent's Name (First, Middle, Las	1)						ate of Death		3. Time of Death		
	Physicia		Patricia A. Sac	ller						vember	оау _{Үөаг} 6,2004	6:30 A M		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of De			4c. County of De			
			3463 Loganview	Drive			Balti				Baltimo			
	Funeral Director		210-30-3024	7. Age	(In yrs. last birt	rhday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (A	ate of Birth fo <i>nth, Day, Y</i> ea /30/195	9. B 0 Ma	inthplace (State or Foreign Country) ryland		
i	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	cation					10d. Inside City Limits		
:	8a-f eho	Director	MD Baltimo	ore	Balti	mor						1 ☐ Yes 2 ☒ No		
:	th with tr		10e. Street and Number 291 Jaydee Aver	nue			10f. Zip Code	1222		10g. (Citizen of What (.A.		
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show sumatic event, the Maryleaf Exar direct has be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XOvorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cubai ☐ Yes 2504No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yerto Rican	es or No- , etc.)	14. Race - An Black, Wh Specify: W	ite, etc.		
5	72 h	Completed	15. Decedent's Ed (Specify only highest gradult)	ucation de completed)	16a.	Deced (Give	ent's Usual Occupa kind of work done d OO NOT use retired,	ition uring most of w	vorking	s/Industry				
7	han.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)									
1	iled v tygie ther t		17. Father's Name (First, Middle, Last)			COM	puter Ope		lame (Firs	t, Middle, Maid		Maryianu		
	d be i	o Be	Roscoe W. Merch	nant				Nett	ie S	irk	, maiden Sumame)			
<u> </u>	Shoul nark mark	2	19a. Informant's Name/Relationship (7		19b.	Mailin	g Address (Street a				y or Town, State,	Zip Code)		
2	nd 2:		Nettie Jones/ N	lother	3	463	Loganvie	w Drive	Bal	timore,	Maryla	nd 21222		
ָ ב	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition		20b. Place of cemeter	Dispos	sition (Name of natory or other place	9)	Date	20c.	Location - City of	r Town, State		
=	Page nent c int: If iry or		1 ⊠Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify				of Faith		/9/0	4 Bal	timore,	Maryland		
	permit. Departn Imports any inju		21. Signature of Funeral Service Licen	see	4.		. Name and Addres							
9	89 = 29		marron	original	1				_		ndalk, l	Maryland 2122		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition. Approximate Interval Between Onset and Death Standard Cause (Final disease or condition).											
F	Physician		Immediate Cause (Final disease or condition resulting in death)	· (NETAS			REAST	CANO	RR			3 mos		
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	of):								
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	uted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
ŝ	n and ial-tra	Еха	resulting in death) Last	Due to (or as a	consequence	of):								
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0	ortificate be executed ing physician and e as the burial-transit	Medical	IF FEMALE:											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brouns after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/P	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death		Ectopic pregnancy Other (specify)				23d. Date of d Month	elivery Day Year		
Ĺ	s that ned b s deta	by Pł	Part II. Other significant conditions of	ontributing to death but	not resulting in	the un	derlying cause give	n in Part I.	2	3e. Did tobacc	o use contribute	to the cause of death?		
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	To the Hospital or Attending Physician: The law requir within 24 hours alter death. To the Funeral Director, After this certificate has been si completely filled in by the funeral director, page 2 should	Completed							-	4a. Was an autopsy performed?	prior to death?	autopsy findings available completion of cause of		
g	an: rtifica tor, p	a)	25. Was case referred to medical					26. Place of C		/\				
_	nysic nis ce direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 □ ER/Ou	tpatient		4 Nursing				ecity) Mothers		
5	ng Pl		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. T	ime of	28c. Injury Work		28d. 0	Describe how in	jury occurred	Home		
2	tendi leath. lor; A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		A11			/es 2 □ No	206.1	anation (Street	and Number or I	Rural Route Number,		
5	or At after of Direct in by	Certification;	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	m, stre	eet, factory, office		201. 0	ity or Town, St	ate)	nulai noute Nulliber,		
	Hospital Hours Funeral tely filled	Medical Co		ysician: To the best of niner: On the basis of e and manner state	examination and									
	To the within 2 To the comple	Med	29b. Signature and title of certifier	1 /			29c. License			29d. (Date signed (Mor	nth, Day, Year)		
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	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 0 2004	32. Registrar	's Signature	1	ported							

State of Maryland / Department of Health and Mental Hygien 2004 35636 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death STEWART November Da **Physician** Edna. 3.45 PM 2004 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner COLUMBIA NURSING HOME HOWARD LORIEN If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 03 21 192 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 254 F Days Hours 83 Yrs. 412-36-07-5 Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene. Important: if flem 27 is marked other than "natural", or flems 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner mast be notified at 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits HOWARD COLUMBIA 1 ☐ Yes 2 ☑ No MD Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10445 HICKORY U.S.A. 21045 RIDGE ROAD . Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK Be Completed by 3 ₩ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NURSING Elementery/Secondary (0-12) College (1-4or 5+) NURSING ATTENDANT 12th avade 31 3 years 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) MARY STEWART/DAUGHTER 10445 HICKORY RIDGE RD. COLUMBIA, MD 2145 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11.10.04 Randallstown, ND KING PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service License 22. Name and Adjoss of Facility VAUGHN C. GREENE FUNERAL SERVICES 5151 BALTINDRE NAT'L PIKE BALTO, MC 21229 23a. Pert1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) BRONCHOPNEUMONA /Medical Examiner Due to (or as a consequence of): Examiner STROKE Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, PERTENSION tean by Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 No 3 ☐ Probably 4 ☐ Unknown SENILE DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? DIGBARE ARJERY 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, f 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Medical Certification: To 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigetion 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9055. TEURILE DWR: # 160 Ellicott UFW · . Mo 21042 31. Date filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

State

Registrar

NOV 1 0 2004

ORIGINAL

Gary Carlton Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health and Mental Hygiene Old Land State of Maryland / Department of Health Andrew / D 04 - 719635637 AKG Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** ton 5:20 A M /Medical November 2004 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital Baltimore 217-52-7 7. Age (In yrs, last birthday) Yrs. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day 6. Sex 9. Birthplace (State or Foreign Funeral 1 M 2 □ F X1 **Director** Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumetic event. The Medical Examiner must be notified at Baltimore Randallstown 1 ☐ Yes 2 ☐ No Completed by Funeral Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 26 Items 23e death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 ö Specify Black 3 Widowed 4 Divorced Year or Dates "neturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Maintenance XYrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK. Unk. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health ar C4. Scot 22 Mainview Kandallstown, Mo item 27 I arlee other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Deremation 3 Removal from State Department of Importent: If it is eny injury or conce. 5 Other (Specify) 1etro remator ° 4 □Donatiøn 21. Signatu a of Funeral Service Inchese 22. Name and Advess of Facility IH 270 FREDHILTON PASS BALTO MOZIZZY Firer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Hypertensive Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE use. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year · jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Narcotic and Cocaine Use 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
Yes 2 No 24a. Was an page 2 autopsy performed? 2 🗆 No 1 Yes Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 🗌 No 2 ER/Outpatient 3 □ DOA 1 XYes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident after death. 1 🗌 Yes 2 🗆 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled within 24 hours a

To the Funerel E

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Commendation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated To the

State Registrar 29b. Signature and title of certifier

ZABILL 31. Date filed (Month, Day, Yes

0 2004

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

November 8, 2004

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Sylvia A. Southan November 4:00A M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6123 Oakland Mills Road Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XX Days Hours 385-36-9952 Yrs. Director Michigan Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-i show Examiner must be notified at 1 ☐ Yes XXNo MD Howard Columbia Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 6123 Oakland Mills Road 21045 USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2XXVo Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Jewelry 17. Father's Name (First, Middle, Last) and Mental H Alvin Balden Alice Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If itam 27 is or other trai John R. Southan/husband 6123 Oakland Mills Road , Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State Department Important: Bany injury o * 4 □Donation 5 □ Other (Specify) Baltimore/Washington Crem 11/05/2004 Laurel, MD 22. Name and Address of Facility Witzke Funeral Homes, 21. Signature of Funeral Service Licensee, Inc. Nelina 5555 Twin Knolls Rd. Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician LEUKEMIA ALUTE CHINCH /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ciscuss or it july Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certilicate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🛣 No 3 Ectopic pregnancy Month Year Day 5 Other (specify) 4☐Pregnant at time of death Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 🔀 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient ပို 1 ☐ Yes 2 X No 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely tilled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Den Dum D0047398 2004 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE . DOUGLAS Mp 1650 ORLEANS STREET 21231 SMITH M D 31. Date filed (Month, Day, Year) **NOV 1 0 2004**. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier Of Land Certificate of Death

			1 - For State Registrar		State of Wi	ai y lai l	Се	rtificate	of E	eath	wentai m	ygieij Reg. No		35	639
	Physici	an	Decedent's Name (First	t, Middle, Las)						2. Date of D		ay ST Year	3. Tim	e of Death
	/Medic	al	ANNA								NOVEN	BER	D1 2004	. 3.	20 M
	Examin	er	4a. Facility Name (If not in			00	Lac	46. City, T	own, or	Location of Dea	ith		County of Death		
	Funeral		5. Social Security Number		OSPITAL X 7. Ag		ast birthday	Kanda If Under 1	Vear	If Under 24 Hi	s. 8. Date of B	irth ⊀	BALTINI 9 Birth	place (Sta	te or Foreign
	Director		225-26-032 Usual Residence of Deced	21 10	⊒м ≱ Д ғ	93	Yrs.	Months	Days	Hours Mi	s. 8. Date of 8 (Month, 1)	рау, Үөаг, 7 1	1 Cou	intry) 1D	te or Foreign
	yland			County		10c. City	, Town or L	ocation						10d. Inside	City Limits
	e Mar	ctor	MD Ba	ltimo	re	Rar	ndall	stowr	1					1 🗆 Y	′es 2ሺNo
	vith th	Dire	10e. Street and Number	_				10f. Zip C					itizen of What Cou	intry?	
	eath v	eral	8511 Allen	swood	Road 12. Was Decedent	Supria II C	112	Was Dassida	211		0		U.S.A.		
Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23s or 28s-f show eny injury or other treumatic event, the Mcdical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2: 3 Widowed 4 D		Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			was Decede If Yes, specif		Specify:	Specify Yes or N rto Rican, etc.)	10-	14. Race - Ameri Black, White		,
2 2	72 ho	sted	15. Do	ecedent's Edu	ication le completed)		16a. Dece	dent's Usual	Occupat	tion uring most of w	orking	16b. K	Kind of Business/Ir	ndustry	
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ary	should be nd Mental marked c	ဥ	19a. Informant's Name/Re	elationship (T	rpe, Print)		19b. Maili	ng Address (Street ar	nd Number or F	Rural Route Num	ber, City	or Town, State, Zi	p Code)	
	tand 2 Health a tem 27 is		Maria Sant	ana-N	iece								timore,		21212
ore	of He of He if item		20a. Method of Disposition 1 □ Burial XIXCren		Removal from State	20b. Pia	ace of Disponentery, cre	osition (Name matory or oth	of er place)	Date		ocation - City or T		
Ë	Pag ment tent: I		`4 □ Donation 5 □ O	ther (Specify)		Met	ro Ci	cemat	ory	Inc.	11/8/0	4 Ba	ltimore	e, Mo	đ
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		21. Signatury of Funeral S	, Va	Kura	Ja	4	300 N	laba	of Facility West sh Ave	e, Balt	imo	re, Md	212	215
			23a. Part1. Enter the dise shock, or heart failur	ase, or comp e. List only o	ications that caused ne cause on each li	the death. ne.	. Do not en	ter the mode	of dying,	, such as cardi	ac or respiratory	arrest,		Approxir Interval	Between
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	_	a		PMEI	JMON	2115					Onsecar	nd Death
	Examiner		, southing in addition		Due to (or as	a consequ	ence of):								
	A UEV	er	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Listans or injury	s, te	b. — Due to (or as	a conseque	ence of):								
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Ö,	e exe ian ar urial-t		resulting in death) Last		Due to (or as	a conseque	ence of):								
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			IF FEMALE:		23c. If yes, outcome	of pregnan	icv.								
Box	that the death ce ed by the attendir detached tor use	Physician/	23b. Was decedent pregn in the past 12 month.	arit	1□Live birth 4□Pregnant at	2 Fetal	death 3	☐Ectopic pred ☐ Other (spec					23d. Date of delive Month	ery Day	Year
P.O.	the d by the ached	hysl	1 Yes 2 No 9 Unknown		9☐ Unknown			(-)							
S, E	law requires that the death ce as been signed by the atlendi 2 should be detached for use	by P	Part II. Other significant of	onditions co	ntributing to death b	ut not resul	lting in the u	nderlying cau	ise giver	in Part I.	23e. Did	tobacco	use contribute to t	he cause o	of death?
ord	w require been sig										10	Yes 2	□No 3□Prot	pably 4	Unknown
Vital Record	e law r has be ye 2 sh	Completed			4.4						24a. Was	psy	24b. Were auto prior to co	psy finding	gs available if cause of
E	Th ate pag	Con									perf	órmed? 2⊠No	death?	21 No	
Vita	ician: Th certiticate rector, pag	Be	25. Was case referred to rexaminer?	-	lospital:						ath (Check only				
ō	Phys this ral dii	. To	1 Yes 2 No	1.	1 Inpatie		R/Outpatier 28b. Time o		_	4 🗀 Ivuising	Home 5 ☐ Res 28d. Describe		6 Other (Specif	(y)	
on	ding th. After	tion	1 Natural 5	Pending investigation	(Month, Day	Year)	Injury	M 200	D. Injury a Work?	es 2 □ No	Zou. Describe	now injui	ry occurred		
Division	I or Attending Physician: after death. Director: After this certitics i in by the funeral director.	Certification;	E C / tooldont	Could not be determined	28e. Place of Injubulding, etc	ury - At hon c. (Specify)	ne, farm, str				28f. Location City or To	(Street an own, State	nd Number or Rura e)	al Route N	umber,
	To the Hospitel or Attending Ph within 24 hours atter death. To the Funerel Director; After th completely tilled in by the funeral	edical C	29a. Certifier f C (Check only one)	ertifying Phy edicel Exemi	sicien: To the best of ner: On the basis of and manner sta	examination	rledge, deat on and/or in	h occurred at vestigation, in	the time	, date and place nion, death occ	e, and due to the urred at the time,	cause(s)) and manner as s d place, and due to	tated.	∍(s)
	To th within To th	Me	29b. Signature and title of	certifier	NO -1	<u> </u>	10.0		License				te signed (Month,		
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	17		30. Name and addre of	person who co	empleted cause of d	eath (Item :	23а) (Туре,	Print) Jr	GIN	DER (MEH-				,
			MOTHWEST	2016	C. C. L. C.	ENT					am 1		1133.		
: 4	Sta	te	31. Date filed (Month, Day	, rear)	32. Registra	ar's Signatu	l'e	1							

			1 - For State Registrar AMEND II	State of Ma TEM #20b PER	aryland / FH G837	Departme Certifica	it of H	ealth and Death	Mental Hy	/gieze	04 3	35640
	Physic /Medi		Decedent's Name (First, Middle Norma				nith		2. Date of D Month 10	eath Day	2004	3. Time of Death 8:07p M
7	Exami		4a. Facility Name (If not institution, Joseph Ritchi	-		4b. City		Location of Dea	th	4c. Cot	unty of Death	
	Funeral Director		5. Social Security Number 216–36–2723	-	e (In yrs. last bi	Yrs. If Under Months	r 1 Year	If Under 24 Hrs Hours Min		irth ay Year) -37		ace (State or Foreign try) Md.
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Location					10	Od. Inside City Limits
	the Ma 28a-f s	ecto	Md. 10e, Street and Number	Baltimore		Randall		n		40.00		1. Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show	al Dir	3801 Schnaper	Drive		101. 21	p Code 211	33			of What Count JSA	try?
336	or ite	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 Yes		spanic Origin? (Specify:	Specify Yes or N to Rican, etc.)		Race - America Black, White, e	itc.
2-00	72 hours "naturel", oleal Ex		15. Decedent' (Specify only highest	s Education	16a	. Decedent's Usu (Give kind of we	al Occupa	ition	nkina		f Business/Indi	
Maryland 21215-0036	within ane. then	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5		`#e. DO NOTE Private		uring most of wo Nurse	y	Vari	ies	
and	uld be filled fental Hygie rked other tic event, u	Be	17. Father's Name (First, Middle, L Henry	ast) H.	Smit	h	18.	18. Mother's Na Rayde	me (First, Middle		oodford	
lary	2 should be and Mental is marked or reumatic even	Jo	19a. Informant's Name/Relationsh			. Mailing Address	s (Street a					Code)
	1 and 1 ealth nm 27		Margaret S. Wil	lis Sister					., Clin			
Baltimore,	8 = 5		1 ☐ Burial ※ ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp	ecify)	_	of Disposition (Na cry, crematory or one nmount C		44/	10/04 8=04		more, I	
Ball	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service L	icensee		22. Name a March		s of Facility . East	Bal 1101 I	ltimore E. NOrt	Md. h Ave.	21202
	Prysician /Medical Examiner	Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause injury Due to (or as a consequence of): Due to (or as a consequence of):									Approximate interval Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	edicai Exa	that initiated events ' resulting in death) Last	Due to (or as a	consequence	of):						
P.O. Box (The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the second of	2 Fetal death	3 ☐Ectopic pi 5 ☐ Other (sp				1	Date of delivery Month D	/ Day Year
Records, P	iw requires that s been signed b should be deta	by	Part II. Other significant condition	s contributing to death bu	t not resulting in	n the underlying o	ause giver	n in Part I.	23e. Did t			cause of death?
al Rec		Completed							1 Yes	osy rmed? 2 No	prior to comp death?	sy findings available pletion of cause of No
Division of Vital	ttending Phys death. stor: After this the funeral di	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no	t be Geo Place of Injur	/ /Year) 28b. 1	Fime of njury M	Other Bec. Injury Work?	4 🗆 Nursing F	th (Check only colone 5 Residue) 28d. Describe I	dence 6 00		Hospice
Div	ital or Attencis after death	Certif	4 Homicide determin	ed 28e. Place of Injur building, etc.	(Specify)	iiii, sireet, factor	г, опісе		28f. Location (S City or Tox	orreer and Nun vn, State)	m <i>oer</i> o <i>r Hural F</i>	route Number,
	To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of kaminer: On the basis of and manner state	examination and	, death occurred d/or investigation	at the time , in my opi	n, date and place nion, death occu	, and due to the rred at the time,	cause(s) and r date and place	manner as state e, and due to th	ed. ne cause(s)
	To T To t	Σ	29b. Signature and title of certifier	M		290	. License	- 1			ned (Month, Da	- 1
	J		30. Name and address of person w	no completed cause of dea	ath (Item 23a) (Type, Print)		- 11/0	Saltimo	Novem	ber 8,	200 9
	Sta	е.	31. Date filed (Month, Day, Year)	cher Hospice 32. Registrar	- 838 's Signature	2 N. Eut	an S	st 13	saltimo	re, MI	212	01
8	Registr		NOV 0 9	. 7	wa	& de	ook	2/				

Norma Jean Smith

State of Maryland / Department of Health and Mental Hygien 👂 \restriction 35641 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marion Month 11 Day L. Martin Smith 4 2004 11:50a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5220 York Road Apt. 9E Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6–13–36 Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director 216-30-1580 Yrs. 68 Md. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director Md. NA Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5220 York Rd. Apt. 9E 21212 Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify. Specify: 3 Widowed 4 Divorced Black "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Nursing Asst. yr. Varies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Gross Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy A. Barr Son 1504 Oleander Ave., Chesapeake, Va. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ita
any injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Mt. Carmel Cem. 11-10-04 Dundalk, Md. 21. Signature of Suneral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave March F.H. East 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiomyopathi disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dus to (cr as a o equence of): Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760 requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ρ Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 2 No 1 Yes of Vital the Hospital or Attanding Physician: Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 23009 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER, 4940 EASTERN AVE., BALTIMORE, ND ZIZZY

10 Day, Year) 32. Registrar's Signature BAYVIEW 31. Date filed (Month, Day, Year) NOV Q 9 2004 Registrar James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35642 State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2004 FIBOA M John Burton Stover /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Sept. 2, Year) **Funeral** Months 1 X M 2 □ F Sept. 80 1924 Illinois 354-18-5484 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland | Montgomery North Potomac Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 20878 11417 Frances Green Drive USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X1Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White natural', or 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1943-46 Specify. δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Aerospace .. Pages 1 and 2 should be fitled wi tment of Health and Mental Hygien tant: if them 27 is marked other th jury or other traumatic event, ILS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Burton Stover Edith Frances Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Perino/daughter 14528 High Meadow Way N. Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 9. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. W. Arundel Crematory 2004 Odenton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Moi35/ Beverly L. Heckrotte, P.A. Clarksville, MD 21029 1) ever 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Distress **Physician** Chronic /Medical Due to (or as a consequence of) **Examiner** Dysphagia Chienic Chumic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Dementia (Halvanied) eniani c The law requires that the death certificate be executed burial-transit Alzheimors the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ funeral director, page 2 should be 2200 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 2 No 1 Yes 2 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 5 Pending investigation 1 Datural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide The Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one)

To the

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State Registrar 29b. Signature and title of certifier

Dul

6105 Montrose Rd. Rockville, MD 20852 Slupla Ameni M.D. 31. Date filed (Month, Day, Year) NOV 0 9 2004 32 Registrar's Signature

and manner stated

pallmin, MB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

10002713

29d. Date signed (Month, Day, Year)

NOV 5 2004

State of Maryland / Department of Health and Mental Hygie Pen 1 L 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Dorothy C. Statter 2:50 AM NOVEMBER 2004 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Baltimore lowson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 7, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Months Days 1 □ M 2 🗓 F 75 213-26-6296 Mary land Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and to them 27 Is marked other than "natural", or Items 23s or 28s-1 show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itema 23a or 28a-1 shov other traumatic event, the Medical Examinar must be notified at Md. Baltimore Lutherville Director 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1529 Charmuth Rd. 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herbert Cypull ပ္ Helen Klutch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pamela Jozwiak/ Daughter 1049 Winsford Rd. Towson, Md. 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of IImportant: If Ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. 11-9-04 Timonium, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fundal Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANOXIC ENCEPHALOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran ASYSTOLE Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as IF FEMALE use use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day 4□Pregnant at time of death 5 Other (specify) P.O. the i þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

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FRONCIS 31. Date filed (Month, Day, Year) HOO.

M. D.

32. Registrar's Signature

OSLER DRIVE, TOWSON, MARYLAND 21204

State of Maryland / Department of Health and Mental Hygien 2004 35644 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 2004 **Physician** 1:28 Ам Saar Margot /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rossville Franklin Woods Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. March 10,1917 9. Birthplece (State or Foreign Country) Estonia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 KF 87 215-30-5663 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County i Hoaith and Mental Hygiene.
Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumstic svent, I'm Medical Exertiest must be notified at 1 Yes 2 No Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9316 Beowulf Circle 21237 Estonia Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes ≥ 2 MNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Library Book Binder 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Hallmann Louise Kruuk Max 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9316 Beowulf Circle; Baltimore, MD 21237 Mari A. Vlachos / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ō <u>=</u> permit. Page Department of Important: If any Injury or 11/9/04 Parkville, MD Moreland Memorial Park 21. Signature of Funeral Service Lidenses 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Pert1. En ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Unnan /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes ed by the a 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performedi 2□ No certificate 2 🖳 1 Tyes : After this certifical funeral director. 25. Was case referred to medical 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient Other: 4 1 Yes 2 No 3 DOA 2 2 ER/Outpatient ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours after To the Funeret Dire To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 10m EdmondSon 31. Date filed (Month, Day, Year) Batimore 11021237 9200 Franklin & 32. Registrar's Signature State Registrar NOV 0 9 2004

State of Maryland / Department of Health and Mental Hygiene 35645 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 **Physician** EILEEN **STURM** Μ. 06 10:05 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8405 MACER ROAD LUTHERVILLE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2/XF 219-32-4422 78 ENGLAND Director Yrs. Usual Residence of Decedent with the Maryland 10a State 10h Counts 10c. City, Town or Location 28a-f show 10d. fnside City Limits other traumatic event, the Medical Examiner must be notified at BALTIMORE MD. LUTHERVILLE Director 1 ☐ Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 8405 MACER ROAD 21093 U. S. A. or Itams 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after d Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itam any Injury or other traumatic event, the Medical Exemples. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XX XIo þ WHITE Specify: XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME YEARS HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARTHUR HENRY YOUNG 2 EILEEN PATRICIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA S. JONES (DAUGHTER) 8405 MACER ROAD, LUTHERVILLE, MARYLAND, 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP. 11-08-2004 TOWSON, MARYLAND, 21204 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Myocardia acuti /Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes XXNo 9 ☐ Unknown Division of Vital Records, P.O. the 9 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed as 2 should b 1 XYes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? page certificate 1□ Yes Y No To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 ☐ Nursing Home SXXResidence 6 ☐ Other (Specify) 2 1 ☐ Yes XX No 1 Inpatient 2 EP/Outpatient 3 DOA After thi funeral 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred XX Natural 2 Accident s after dea. 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in t within 24 hours at To the Funeral D completely filled it 1 XIX certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 8,2004 leining 10040208 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) York Rd Sta une Bremermo 32C Lutherville 1205 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Amend item#19a, per INF , 6837, 11/15/04 III

State of Maryland / Department of Health and Mental Hygiene () () L 35646 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Melvin Stidham November 8. 2004 11:30A /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 2, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Yrs 218-12-7092 Director 86 1918 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28a-f show id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Lutherville Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21 Arverne Court 21093 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other treumatic event, to we United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sr. Systems Analyst Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stidham James Anthony Edna Mitchell 19a. Informant's Name/Relationship (Type, Print)

Mary Cloyd Daughter)

Mary Cloud/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arverne Court Lutherville. MD. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Dulaney Valley Mem. 11/12/2004 Timonium, MD. 4 □ Donatijon 5 □ Other (Specify) 21. Signature of Faneral Service Licens ee Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility Stephen Coster 1050 York Road Towson, Maryland 21204 23a. Pert1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Judden 10 MIN /Medical Due to (or as a consequence of) **Examiner** 20 YEARS ATHEROSCLEVOSIS S—nuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ルタ Records, I þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has Vital 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only or Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To ₹ ER/Outpatient 3 DOA After this 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 8-1 ision Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident investigation hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4460 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 9512 HARFORD 21234 BATIMORE MO 32. Registrar's Signature State AUV 0 9 2004

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 35647 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death NOVEMBERDAR, 2004 **Physician** SAGER 5:08 A M ELEANORE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10112 SPRING POOLS LANE COLUMBIA If Under 24 Hrs. HOWARD If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Day, Year) JAN. 26, 1921 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🙀 F 83 Yrs Director 200-18-3810 PA Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10112 SPRING POOLS LANE or Items 23a 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I provide important: If them 27 is marked other than "natural", or flear any injury or other traumatic event Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NATHAN STEIN ဥ **ESTHER** UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRUCE SAGER / SON 10112 SPRING POOLS LANE - COLUMBIA, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 💢 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MONTEFIORE CEMETERY 11/09/2004 JENKINTOWN, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Toleto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner AMYOTROPIC LATERAL SCLEROSIS Sequentially list conditions if any, Isading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician ian/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy of in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Physic the 9 Unknown 9 Unknown \$ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 X No 1 Yes 2 🗆 No 1 🗌 Yes the Hospital or Attsnding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: P 1 ☐ Yes 2 🏋 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Diractor in 24 hour.
the Funeral Direc. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DD03829 8/04

State Registrar DHMH 17 Rev 1/2001 Johns Hopkins

32. Registrar's Signature

Univesity

600 N. Walk St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) twin

31. Date filed (Month, Day, Year)

NOV 1 0 2004

State of Maryland / Department of Health and Mental Hygien 🦻 🛭 🗎 35648 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year TURNER 7:32 A M November 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death **Examiner** of Baltimore Manyland N/A6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye MAY 12, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** · 1951 MARYLAND 1 M 2 X Months Days Hours Min 53 Director 58 4316 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show treumetic event, the Mudical Examiner must be notified at Director 1 ☐ Yes 🏋 ☐ No MD. BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Items 23e 108 SOLLERS POINT ROAD 21222 U.S. OF A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpaBaLACK ģ 3 Widowed 4 Divorced Year or Dates: naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH UNKNOWN RESIDENCE DAY CARE PROVIDER other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other treumetic event 17. Father's Name (First, Middle, Last)
MORRIS Mc CREADY ^{18. Mother's Name (First, Middle, Maiden Sumame)} FANNIE MAE SMALL (DECEASED) (DECEASED) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) 104 rogers cockrell la. CRYSTAL SHIRD BALTIMOREMD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) MT. ZION CEMETERY 11/11/04 LANSDOWNE, MARYLAND 21. Signature of Funeral Service Licensee

LEWIS T. GWYNN LEWIS TO STORE GWYNN FUNERAL HOME 21215-6393 23a. Part). Enter the disease, or complications shock, or heart failure. List only on complications of the complex of the comp 4517 PARK HEIGHTS AVENUE ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, attending physician iclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the detached Physi 9 Unknown The law requires that the 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 Yes 2 No 3 Probably 4 Whknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has certificate 1□ Division of Vital Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation Injury death. 1 □ Yes 2 Accident Director: in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier 29b. Signature and title of 30. Name and addre cause of death (Item 23a) (Type, Print) South Greene 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 0 2004 NOV Registrar

State of Maryland / Department of Health and Mental Hygier 0 0 1 35649 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 3004 **Physician** NOVEMBER 1132AM Paul Franklin Tucker, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1**X** M 2□ F 234-74-6320 Director 58 10/25/1946 West Virginia Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, It e Madical Examinar must be notilized at 1 XYes 2 ☐ No Director MD Havre de Grace Harford 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 607 Otsego Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1963 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) GED Truck Driver Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Dewey Tucker Clyta Pearl Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other term Myrtice Tucker- Wife 607 Otsego St., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ■ Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Harford Mem. Grdns. 11/06/04 Aberdeen, MD 21. Signature of Funeral Service Licenses Mitchell-Smith Funeral Home, Y 123 S. Washington, Havre de Grace, MD 21078 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SHOCK Pnysician HOURS /Medical Due to (or as a consequence of): Examiner METASTATIC LIVER CANCER Sequentially list conditions, if any, bearing to initial acase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examiner use as the burial-transit METASTATIC LUNG CANCER Due to (or as a consequence of): COAGULOPATHY Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 LIVER METASTASES, HEART DISEASE, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHADNIC OBSTRUCTIVE PULMONARY OBEASTE DISTENTION ABDOMINAL 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BYRVE 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN BYRME 500 UPPER CHES 500 UPPER CHESA PEAKE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MON 1 0 2004

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State of Maryland / Department of Health and Mental Hygien 2001

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	Physic /Medi		1. Decedent's Name (First, Mi	•	lliam	H. Tubi	nan				2. Date of D Month NOVEM	eath Da	у	Year	3. Time o	М	
	Examir		4a. Facility Name (If not institu KERNAN HOSPITA		street and nu	ımbər)		4b. Cit		r Location		TY	4c. County of Death N/A				
	Funeral Director		5. Social Security Number 220-36-5900	6. Se	ex ☑M 2□F	7. Age	(In yrs. last birtho	Month	er 1 Year S Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D Jul 24	irth <i>ay, Year)</i> 1, 1939	year) 939 9. Birthplace (State or Foreign Country) Virginia			
	the Maryland 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. Cou Delaware	ity			10c. City, Town o	r Location	[Dover					E	10d. Inside C	City Limits
	n with the 23a or 28 st be not	Funeral Director	10e. Street and Number 341 Beach wood A	ve.	<u>-</u>			10f. 2	ip Code	1990	01		10g. Citizen of What Country? U.S.A				
036	ges 1 and 2 should be illed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic evant, the Medical Examinar must be nutified at	Þ	11. Marital Status 1 □ Never Married 2 ☑ N 3 □ Widowed 4 □ Divord		12. Was Dec Armed For 1 Tes If Yes, Gi Year or D	orces? 2 ☑ No ive		If Yes, sp	edent of Feerify Cuba 2 X No	lispanic Or an, Mexica Specify	n, Puerto	ecify Yes or N Rican, etc.)	0-		ck, White,	can Indian, , etc. Black	
7	within 72 ho piene. r than "natur the Medical	Completed	15. Dece (Specify only hig Elementary/Secondary (0-12	hest grad			(9)	ecedent's Us live kind of v fe. DO NDT	vork done use retire	durina mos		king 16b. Kind of Business. W.R. Grace				al	
73	should be filed within and Mental Hygiene. markad other than imatic evant, the Me	To Be C	17. Father's Name (First, Midd		Tubman		`			18. Moth	er's Name	(First, Middle Ma	e, Maider				
, Mar,	and 2 sho salth and I n 27 is me ar trauma		19a. Informant's Name/Relation Alice Tubman Wif		урө, Print)		19b. M	-					Route Number, City or Town, State, Zip Cod Delaware 19901			Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if itam 27 is any injury or othar trae		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic 1 ☐ Donation 5 ☐ Other			State	20b. Place of D cemetery,	isposition (N crematory of Loudor	other plac	ce)		11/13/04	20c. L		City or To	own, State e, MD	
Balt	permit. Pa Departmen Important: any injury		21. Signature of Funeral Serv	e Licens	se6	1	•	22. Name E	step B	rothers	Funera	al Home F altimore, M	P.A. 1D 212	217			
	Priysician /Medical Examiner	miner	23a. Part 1. Enter the alsease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	st only o	a. a. b.	each line (or as a	7.974	V (05	1911			yaxule.	4	S	æ_	Interval Bet Onset and	tween Death
	certificate be executed iding physician and ise as the burial-transit	/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	l	c	(or as a	consequence of)										
	es that the death certific igned by the attending be be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth 2 nant at ti	i pregnancy □Fetal death me of death	3 Ectopic 5 Other (y					te of delive		Year
ras, r	w requires that been signed b should be deta	by	Part II. Other significant cond	itions co	ontributing to d	death but	not resulting in th	e underlying	cause giv	en in Part	l. 		tobacco i			he cause of c	death? Unknown
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or vital	Phyaician: Th this certificate ral director, paç	o Be	25. Was case referred to med examiner? XXYes 2 \(\sum \) No	-	Hospital:	Inpatien	2 ER/Outpa	utient 3□1	Oth	000		n <i>(Check only</i> me 5 ☐ Res		e Cloth	or /Cassil	h a)	
lon of	ding After fune	ation; To	27. Manner of Death 1 □Natural 5 □ Per 2 □ Accident inve	stigation	28a. Date		28b, Tim	e of	28c. Injur Wor			28d. Describe				inch	rad
\leq	Dire	Medical Certification:	4 ☐ Homicide det	ld not be	build	ding, etc.	y - At home, farm (Specify)	stree	+			DOVE	WIT, State	eb.	burg	Keal of	Pleel !
	a Hospital 24 hours a E Funaral I etely filled	dical			iner: On the b		my knowledge, o examination and/o ed.										s)
)	To the within To the Comple	Me	29b. Signature and title of cen	fier (B00	·		2	9c. Licens					-		Day, Year)	
4	۲		PatricinA	CANC	A- 10	MAKN	ath (Item 23a) (Ty		et, B	altim	ore,	Maryla	and 2	1201	L		
	St. Regist	ate rar	31. Date filed (Month, Day, Ye			Registrar	's Signature	So	ocks	1		-					

State of Maryland / Department of Health and Mental Hygien [] 35651 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death **Physician** Year 06, 2004 Benjamin S. Toney November 12:58P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 12-03-1939 Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1(XM 2□ F 216-34-4000 North Carolina Director 64 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show traumatic event, the Medical Examiner was be notified at 1 XYes 2 No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1532 N. Rosedale Street 21216 USA Items 23e Completed by Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced USA "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked o Workman Toney Geneva Cousar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i 28 S. Broadway St. Baltimore, MD 21231 Benjamin Toney Jr/Son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If its eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 11-10-04 Lansdaowne, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home 638 N.Gilmor St. Balto, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METAJTATIC Pnysician MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dualto (or as a nonsecuance of): Examiner cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, funeral director, page 2 should be C CYCEBROVAS CURAN DUGAJE 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 100 27. Mann Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral L 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dy Jans inn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mn 750 5 TARIS 03652 CM WOLWOT DAIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV Q 9 2004 rocks Registrar

State of Maryland / Department of Health and Mental Hygiepen 35652 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:08 P. M DOLORES VONDERSMITH 11 2004 04 -/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN NURSING CENTER BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) July 28, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗷 F Maryland Director 219-10-9272 89 1915 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2**X**X\0 Directo Baltimore Baltimore Mď. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6401 Loch Raven Blvd. 21239 Itams 23a Apt. 526 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itan any injury or other traumatic event, If a Madical Exact Black, White, etc. ☐Yes 2XXNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Marie Bayrle Noble G. Pickerina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2327 Northcliff Dr. Jarrettsville, Maryland 21084 Mrs. Paula Moore/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp.¦11/6/04 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD H. Kutt RUCK TOWSON FUNERAL HOME, INC. TOWSON.MD.21204 Approximate Interval Betwe Onset and De 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Carcinoma of MUNTER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes V No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. þ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy XXNo 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other 4XX ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred After s after decral Director: Atte X X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 0 9-17041 NOVEMBER 05,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lutherville MV Mare I. 1205 Leavey my 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien on the

	State of Maryland / Department of Health and Certificate of Death		en2004	35653
Olympiais	1. Decedent's Name (First, Middle, Lest)	2. Date of Deeth Month	Day Year	3. Time of Death
Physician /Medical	ERMA THERESA WILSON	NOV. 4	2004	7:50AM
Examiner		r Location of Deeth	4c. County of Death	
1	MANOR CARE-ROSSVILLE ROSSVI	LLE	BALTIMORE	
Funeral	5. Social Security Number 6. Sex 1 M XXF 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hr Months Deys Hours Mir		(ear) 9. Birthpla	ce (State or Foreign
Director	216-01-268/	Feb. 13,	1918 Mary	land
pue 🕷	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		100	d. Inside City Limits
Aaryi f sho	Maryland Baltimore Baltimore County			1 ☐ Yes 2 💢 No
the the property of the proper	Maryland Baltimore Baltimore County 10e. Street end Number 10f. Zip Code	100	. Citizen of Whet Countr	v?
villa or control	76 Yew Rd. 21221			, .
J ifter death with the Ma river neat be notified Finanal Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - America	n Indian,
Tire the	Armed Forces? If Yes, specify Cuben, Mexican, Pue 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Specify Cuben, Mexican, Pue 1 □ Yes 2 □ No 1 □ Yes XIX No Specify:	rto Rican, etc.)	Black, White, et	
E E E	If Yes, Give \(\) Yes \(\) Yes \(\) Yes \(\) Yes \(\) Yes \(\) Yes \(\) Yes \(\) Yes \(\)		Specify: Whit	te
Q 21215-0020 filed within 72 hours effer death with the Marylend Hygiene. wher than "natural", or ferms 23a or 28s-f show ant, the Medical Examiner must be notified at a Completed by Filmeral Director	15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of we life. DO NOT use retired)	16	b. Kind of Business/Indu	stry
The second	Elementary/Secondery (0-12) College (1-4or 5+)			
	10 yrs. N/A Housewife		ousekeeping-	-Own Home
tal High	17. Father's Neme (First, Middle, Last)	ame (First, Middle, Ma	,	
VISA ould Men Men Men Men Men Men To	Joseph Reinhardt Anna	Elizabeth	Woppman	
A Car	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fig. 19b. Mailing Address)	Rurel Route Number, C	City or Town, Stete, Zip C	ode)
BAIKIMOFE, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylen Depertment of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Experiment must be notified at once. To Be Completed by Firneral Director	Erma Jane Hagert(Daughter) 76 Yew Rd. Baltimore 20a Method of Disposition (Neme of			
or of the	J⊠ Burial 2 □ Cremetion 3 □ Removal from State cemetery, cremetory or other place)		c. Location - City or Tow	
timer tmer tant:	4□Donation 5□Other (Specify) Gardens of Faith Cemetery	11-8-04 E	Baltimore, N	1d
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours elt Deperment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or Important: other traumatic event, tre Medical Exprinance. To Re Completed by F	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral	Home		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	Baltimore		pproximate iterval Between
rdificate be executed and physician and as the buriel-transit unipply Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last April 5 Sole notic (Caudu') Ulas Due to (or as a consequence of): Due to (or es a consequence of): Due to (or as e consequence of):	scular	disasp	
The Cords, P.O. BOX of the law requires that the death certifiate has been signed by the attending page 2 should be deteched for use a completed by Physician/Me.	d		1	-
the a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	cco use contribute to ti	ne cause of death?
Productive of by the detection Dry specification of the detection of the d	CHE	1 ☐ Yes	2 No 3 □ Probai	bly 4 ☐ Unknown
In records, The law requires th cate has been signe, page 2 should be o		24a. Was an a	24b More	autopsy findings
requirement should		performed	d? availa	able prior to eletion of cause
के इंट 🖸		- TIL	∧ of de	ath?
Cate Cate		† ☐ Yes	101	∕es 2□ No
VItal I	examiner?	ath (Check only one)		
Physic this call direction 170	TE inpatient 2 Ervoupatient 3 BOX		e 6 Other (Specify)	
ing ling After fune	Maturel 5 Pending (Month, Dey Year) Injury Work?	28d. Describe how	injury occurred	
To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	it and Number or Rural F Itate)	loute Number,
To the Hospital or within 24 hours effe to the Funeral Dir. completely filled in Medical Cert	29a. Certifier (Check only one) Check only one)	e, and due to the caus urred at the time, date	e(s) and manner as state and place, and due to th	ed. e cause(s)
To the some	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, De	y, Year)
1	1 1 M Lya Da 1 0510979	11	1/4/02	
0	30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)		1	
V	7845 bakwood RD Ste 100 Cheu Burns	e Mo	21061	
State	31. Dete filed (Month, Day, Year) 0 2004 32. Registrar's Signature & Society			

State of Maryland / Department of Health and Mental Hygien [] [] 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:50 Ат. м Richard Wilson 11 7 - 2004/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkridge
| Under 1 Year | Hours | Min. | 8. Date of Birth (Month, Dey, Year) | Feb 3, 1921 6048 Meadowridge Rd. Howard If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ X/4 2 □ F 220-05-2911 83 Márvland Director Usual Residence of Decedent the Maryland 10d. tnside City Limits 10a State 10b. County 10c. City. Town or Location show Examiner rount by notified at 1 Yes 2 No Maryland Howard Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ with 21075 U.S.A 6048 Meadowridge Road itепs 23a death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ ¥lo Specify: tf Yes, Give Year or Dates: Black 3 □XVidowed 4 □ Divorced "natural" or than "natura the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) Coltege (1-4or 5+) U.S. Agriculture 12 Department of Health and Mental Hygi Important: if item 27 is marked other any injury or other traumatic evant. If ODCS. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isabelle Wilson Richard Wilson Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 97 Box 6 Glenwood, Md. 21738 Emma Matthews Sister 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Surial 2 Cremation 3 Removal from State 11/12/04 Elkridge . Maryland Meadowridge Memorial Park * 4 ☐ Donation 5 ☐ Other (Specify) Estep Bros. Funeral Service P.A. 1300 Eutaw Pl. Balto. MD 21217 21. Signature of Funeral Service Licenses E.N. Walker Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comptications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) neumonia Physician /Medical Examiner Sequentially list conditions, it any, isaumy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician a hed for use as the burial-P.O. Box 68760, olon Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Division of Vital Records, þ 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Yes 2 No ို 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manney of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)
November 8th 2004 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) SU2AN Abdo 5005 Signal B ell lane Clarksulle MD 21029

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 0 2004

32. Registrar's Signature

Pt. Kuowa as Mary Washing ferl

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2 0 0 4 35655 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Washington 24,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Sinai Hospital Baltimore of Baltmore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 M 2 F 216-44-1983 Director 78 Yrs. 12-19-25 MDUsual Residence of Decedent 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or items 23a or 28e-f show other traumatic event. Its Mudical Examinar must be notified at 10d. Inside City Limits Director MD 1X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Penhurst Ave 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 XNo δ 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi Health and Mental Hygien tem 27 Is marked other th 8th Unknown Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau <u>once.</u> Carla Ranson 10 N. Calvert St. Balto. MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Carmel 11-10-04 Dundalk, MD 22. Name and Address of Facility Wesley Chavis Jr. F.H 2007 Eastern Ave Balto, MD 21231 23a. Park: Inter the dise so, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive heamt 30 minues disease or condition resulting in death) /Medical **Examiner** the rus clorric 10423 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or as a consequence of physician and the burial-transit The law requires that the death certificate be executed Hypertasian 0043 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medlcal use IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Demention 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 2 No 2 No 1 🗌 Yes 1 🗌 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of bertifier 29c. License number 29d. Date signed (Month, Day, Year) D 36494 11/3/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIE maiden cherce lone sturt dol Baltimae ma 21828 CDESAlm 32. Registra s Signature 31. Date filed (Month, Day, Year) NOV 1 0 2004 State Registrar

State of Maryland / Department of Health and Mental Hygieng () L

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEW BER Physician Year Frederick Todd Wuechner 820 P 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3701 Love Road Darlington Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 22, 1963 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√2 M 2□F 40 215-94-5217 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Md. Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 Love Road 21034 U.S.A. Funerai filed within 72 hours affer death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 № Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 7 years truck driver distribution 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 Is marked any injury or other traumatic evones. Frederick W. Wuechner Matilda Loretta Wolfe Gavin 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Gavin/mother 905 Wheel Road, Bel Air, Md. 21015 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11/9/2004 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 100 to 100 t Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hanging disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the burial Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an perform 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1

Yes 2 □ No After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 8t. Uccation (Street and Number or Rural Route Number, by or Town, State) investigation 1 ☐ Yes 2 No NOV 4, 2004 820 2 Accident filled in by the within 24 hours after deal To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 14206 person who completed cause of death (Item 23a) (Type, Print) 2018 HOLADIKO AVE BALTO MC 21222 YUKM, MO, DONE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 0 2004

Amend item#20b, perril, C837, Printin Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James Wilson 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hanss ItIMO 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 2 M 2 ☐ F 8. Date of Birth (Month, Day, Ol 11 Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Hours Min. Days 76 Director MD 218-22-7721 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural; or items 23a or 28a-f show traumatic event, the Medicul Examinating transit be notified at 1 ¥ Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Joicy Ct. 21207 U.S.A. death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or 12 any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 ◯ No Black Ď Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12th grade College (1-4or 5+) Painter MD Dry Dock 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Sue Wilson Chance Goodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Alston-Daughter 6 Joicy Ct. Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/17/2004 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 11/9/04 Owings Mills, 21. Signeth e of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheraseles Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if my land groups cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23h Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autoosy perforn 2 2 No 1 🗌 Yəs Be 25. Was case referred to medical 26. Place of Death Check only one examiner 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient Certification: To ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide retrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number Attending Physicia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (NIE NOT) Caton 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NOV 1 0 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 35658 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death AYMOND **Physician** Month Year 12:501 November, 06 2004 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bultimore
If Under 24 Hrs.
Hours Min.
8. Date of Birth
Month, Day,
MAR. 21, Home Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 215-30-257 1 M 2 □ F Days 70 MORYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "netural", or items 23e or 28a-f show other traumatic event, the Madical Examinar must be muiffed at 10d. Inside City Limits NIA **Funeral Director** MD BALTIMORE Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CARVER 21225 USA 2809 RD Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) arpenter 5choo! oth Depenment of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, If 20108. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Young Kaymond Mildred 19a. Informant's Name/Relationship Type, Print) Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Gertina Balto. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 MBurial 2 Cremation 3 Removal from State Cemeters 4 Donation 5 (Specify) 21. Signature Funer Service Licens ARY P. MARCH FUNERAL HOME P.A. 70 FREDHILTON PASS BALTO, MD 21229 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner In necords, P.O. Box 68760, The law requires that the death certificate be executed buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, attending physician for use as the burie Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown OBSTRUCTIVE Be Completed by page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen efter death.

Director: After this certificate hes in by the funeral director, page 2: 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place Death (Check only one) Other: 4 Universing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yeş 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending P 1 Natural 5 Pending investigation 2 🗆 No 2 Accident 1 Tyes To the Hospital or Atter within 24 hours efter der To the Funerel Director completely filled in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 1 0 2004

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 20 01. 35659

			1 - For Stata Registrar	State of Ma			tment of F ificate of	lealth and N <i>Death</i>		Gleneu (Reg. No.	04 3	50000
	Physici	an	1. Decedent's Name (First, Middle, Las.						2. Date of Dea	ath Day	Year	3. Time of Death
	/Medi	al	Jose Daniel Zar			-			NOV.	1, 20	004	0640 A ^M
1	Examir	er	4a. Facility Name (If not institution, give JAIL CELL/JAIL 41	1/NAYLOR	MILL ROA	AD ,	SALISE	r Locetion of Death SURY		4c. Cou W.	Inty of Death)
	Funeral Director		0//-42-1916	X 7. Ag XM 2□F	e (In yrs. last birt 56		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct. 18	, Year) 1948	9. Birthp Coun Arge	lace (State or Foreign try) entina
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ition			·	11	Od. Inside City Limits
	Many Many	tor	Maryland Wicomico		Salisbu	ry						1 ☐ Yes 2 📉No
	th the	lrec	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	try?
	23a	ral	411 Naylor Mi				21801					(UNK)
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic event. I'm Madical Examinar must be notified an ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. No		as Decedent of H es, specify Cuba Yes 2 X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	+	Race - America Black, White, e Broify: Whit	etc.
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lar	ould be Mental sarked o	To Be	Jacque Zarou					E1sa			(UNK)
, Maryland	ind 2 sho alth and 1 27 is me		19a. Informant's Name/Relationship (7) Jacqueline Zarou/		19b. 22	Mailing . 9 Go	Address (Street of Driv	and Number or Rur e Aberdee	en, Mary	r, City or Tow land 2	wn, State, Zip	Code)
Baltimore,	Pages 1 and of the port: If item		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 1 □ Donation 5 □ Other (Specify)				ion (Name of tory or other place . Cremate		mber o		on - City or Tov	
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90,	rificate be executed g physicien and as the burial-transit		resulting in death) Last	Due to (or as	a consequence o	if):						
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.O. Box 6	death cei e attendir d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{tes} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		topic pregnancy ther (specify)				Date of deliver	y Day Year
s, P	The law requires that the death tie has been signed by the atter bage 2 should be detached for u	by	Part II. Other significant conditions co.	ntributing to death bu	it not resulting in	the unde	erlying cause give	an in Part I.			ontribute to the	cause of death?
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Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	nt 2 ER/Out		3D DOA Othe	26. Place of Death			_	AM COPAT
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Division	el or Attendi s after death. It Director: A id in by the fu	27. Manner of Death 1								reet and Nur , State)	mber or Rural i	Route Number,
	To the Hospitel or Att within 24 hours after de To the Funerel Direct completely filled in by the	edical	29a. Certifier 1 Certifying Physical Check only one) 2X Medical Exami	sician: To the best of ner: On the basis of and manner sta	f my knowledge, examination and led.	death od /or inves	curred at the tim tigation, in my op	e, date and place, inion, death occurr	and due to the ca	use(s) and rate and place	manner as states, and due to t	ted. he cause(s)
	Totl withi Totl comp	ž	29b. Signature and title of certifier	000			29c. License		25	_	ned (Month, D	
			Holvill	- Tolle	e mo			C.M.E		NOV.	2, 20	004
	1		30 Name and address of person who co	ompleted cause of de				Baltimo	re, Mary	land 2	2120 1	
	Sta Registr	_	31. Date filed Wenth Oas Year 04	32. Registra	r's Signature	de	rocks					

			1 - For State Registrer	State c	f Marylar	nd / Depa <i>Cer</i>	artment of H	lealth and Death		iene 20	104	35660
			1. Decedent's Name (First, Middle, Las	st)	· -				2. Date of Deat	h		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give			ccassic	4b. City, Town, or	r Location of De		4c. County		Z.ZZ A.
	_xamm	61	Holy Cross Hospit	a 1			Silver	Spring		Montgo	mert	7
	Funeral		5. Social Security Number 6. Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H			9. Birthr	place (State or Foreign
	Director		218-68-3232	□M 2 X □F	70	Yrs.	Months Days	Hours M	in. (Month, Day, May 18,	1934	Cour Fr	ance
			Usual Residence of Decedent					·	1220			
	yiang Now		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	·			1	0d. Inside City Limits
	Mar	to	Maryland Montgome	rv		Rockvil	11e					1X Yes 2 ☐ No
	158 158	Director	10e. Street and Number			110 011 1 1	10f. Zip Code		10	Og. Citizen of V	Vhal Cour	ntry?
	3a o	۵	712 Azalea Drive				208	50		USA	\	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow ant, tra Madical Esarinar must be notified at	Funeral	11. Marital Status		edent Ever in U	.S. 13. V			(Specify Yes or No-			can Indian,
	fer of the rest	ᆵ	1 Never Married 2X Married	Armed Fo 1 ☐ Yes		l:	Yes, specify Cuba	ın, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Blac	k, White,	etc.
8	Irsa Ir, or	þ	3 Widowed 4 Divorced	If Yes, Gi Year or D	ve	1	I□Yes 2⊠No	Specify:		Specify	Whi	†o
ŏ	thor sture	ed	15. Decedent's Ed	ucation		16a. Deced	fent's Usual Occup	ation		16b. Kind of Bu		
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0	filed Hyg Sther		17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle, M			
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", or Items 23s or 28s-f show amount into your properties. It is not that the unsate ovent, the Medical Examination at a page.	-	19a. Informant's Name/Relationship (Odii		a Address (Street	and Number or	Rural Route Number,			
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ō,	1 ar Hea am 3		20a. Method of Disposition	/ Husbai	20b. F	lace of Dispos	sition (Name of			20c. Location -		
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Baltimore,	rtme rtant		` 4 □ Donation 5 □ Other (Specify		Nor					Olney,		land
a B	Depa Mpo Iny i		21. Sign dure of Funeral Service Licen	7/10	OV				DeVol Fune			
	40 = 8 Q		1 were		ever				Dr., Gait		g, M	
D.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on i	caused the deat each line.	h. Do not ente	er the mode of dyin	g, such as card	iac or respiratory arre	st,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	Stage	III Ov	arian	Cancer					Onset and Death
	/Medical		resulting in death)	u	(or as a conseq							
	Examiner		Sequentially list conditions	b								
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Ö,	e exe	Ψ.	resulting in death) Last	Due to	(or as a conseq	juence of):						
8760,	icate be executed physician and s the burial-transit	dical		. d								
ထ	eath certific attending pl for use as t	0	IF FEMALE:									
Вох	th ce tendi	an/l	23b. Was decedent pregnant		tcome of pregna pirth 2 Fete		Ectopic pregnancy				e of delive	,
о. П	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 🖾 No	4☐Prega 9☐Unkn	nant at time of d		Other (specify)			Mor	nn	Day Year
<u>Ч</u>	The law requires that the death certifi ste has been signed by the attending age 2 should be detached for use as	Physician/M	9 🗆 Unknown									
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Division of Vital Records,	Attending Physician: r death. sctor: After this certific by the funeral director.	O.B	examiner? 1 ☐ Yes 2X No	Hospital: 1 🔀	Inpatient 2	ER/Outpatien	t 3 DOA Othe	0.01	Home 5 Reside		or (Specifi	v)
0	ding Ph	H	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Injun	/ at	28d. Describe ho		_	,
Ö	nding F th. :: After e funera	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		th, Day Year)	Injury	Worl M 1□	k? Yes 2 □ No				
S	after death Director: in by the	ifica	3 Suicide 6 Could not be	200. Flaut	of Injury - At h	ome, farm, stre	eet, factory, office		28f. Location (Str	eet and Numbe	or Rura	l Route Number,
á	afor A after Direct	Certification:	4 Homicide determined	build	ing, etc. (Specif	y)			City or Town,	, State)		
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in It		29a. Certifier 1 X Certifying Ph	ysicien: To the	best of my kno	wledge, death	occurred at the tim	ne, date and pla	ce, and due to the ca	use(s) and mai	nner as st	ated.
	e Ho 24 t e Fu letely	Medical	(Check only 2 Medicel Exan	niner: On the b and man	asis of examina ner stated.	ition and/or inv	estigation, in my of	pinion, death oc	curred at the time, da	te and place, a	nd due to	the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier				29c. License	e number	29	d. Date signed	(Month,	Day, Year)
	J						D	60610	0	tobe-	20 ′	2004
	1		30. Name and address of person who	completed cau	se of death (Item	n 23a) (Type I		60619	00	tober	۷, ۵	2004
			Connie Le, M.D.,					r Sprin	o. Marvlar	d 2090	1	
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	Registr		OCT 26 200	4 3	neva	19	Sporks					

State of Maryland / Department of Health and Mental Hygien 2004 35661 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** PM Brickewater 8:34 October 2004 Darry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Georges Hospital heverly, Maryland Georges Prince Prince Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min Yrs. 27, 36 DEC. 1967 MARYLAND 577-82-0791 Director Usual Residence of Decedent p-mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow any injury or other traumatic event, it is Medical Examinant be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 XYes 2 ☐ No Directo PRINCE GEORGES SUITLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3394 CURTIS DR. #204 20746 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify. Specify. Completed by 3 Widowed 4 Divorced Year or Dates: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRUCKING 12 TOW TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BRIDGEWATER LOIS Ε. COUNTS GEORGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3394 CURTIS DR. #204, SUITLAND, MD. 20746 LOIS E. BRIDGEWATER/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State C * 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY NOV.1, 2004 RIVERDALE, MD. 21. Signature of Funeral Service Lipensee 23a. Part1. Enter the disease, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 2073/ Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiogenic Shock **Physician** /Medical Due to (or as a consequence of): **Examiner** Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed burial-transit Coronary vears the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, tor use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown from pencardial tube, massive pencardial 2 No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No dilated cardiomyopally, end 24a. Was an autopsy performed? Yes 22 No chronic disease, certificate hypertension 1 Yes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To tuneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No hours after death investigation the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my onigion, death occurred at the time. within 24 hours a
To the Funeral I
completely filled To the Hospital 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD Linley DST130 October 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravinder K. Rustagi, MD 6132 Landover Road, Cheverly, MD 20185 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiether) 0.1.

			1 - For Amend Item 3 per phy G837 1	1-17- Cer	O4 tas tificate of De	aith and M eath			35662					
	Physici /Medi	al	HAVILAND BIENSTOCK				2. Date of Dea Month OCTOB	ER ^{Day} 20, ŽÕ						
	Examir	er	4a. Facility Name (If not institution, give street and number) 7420 WESTLAKE TERRACE #1004		4b. City, Town, or Lo			4c. County of Death MONTGOMERY						
	Funeral Director		5. Social Security Number 6. Sex $1 \square M$ $2 \square F$ 7. Age (In yrs. las 204-01-9285 84	t birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth Month, Bay AUG • 8 •	9. 1 1920 PE	Birthplace (State or Foreign NNSYLVANIA					
	ryland how			Town or Lo	cation				10d. Inside City Limits					
	the Ma 28e-f s	Director	MARYLAND MONTGOMERY BE	ETHESI				10- 0"	1 XYes 2 □No					
	h with 23e or 3	al Dir	7420 WESTLAKE TERRACE #1004		10f. Zip Code 208	17		IOg. Citizen of What ITED STAT	ES OF AMERICA					
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Modical Examitter must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ XWidowed 4 □ Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of Hispa Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. WHITE					
15-0	n 72 ho "natu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give)	ent's Usual Occupation kind of work done duri OO NOT use retired)	on ing most of working	ng	16b. Kind of Busine	ss/Industry					
212	d withi giene. er then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		CRETARY			EDUCAT	ION					
Maryland	uld be fite Aental Hy rked oth tic event.	To Be (17. Father's Name (First, Middle, Last) ISRAEL ZUCKERMAN		18		(First, Middle, I	Maiden Sumame)						
Aary	2 short and N is ma		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and									
	tem 27		STEVE BIENSTOCK - SON 20a. Method of Disposition 20b. Plac		POTOMAC, MD 20878 Location - City or Town, State									
Baltimore,	it. Pages rtment of rtent: If i		'4 □Donation 5 □Other (Specify) WASE	IINGTO	natory or other place) ON CEMETER				UNCTION, NJ					
Ba	perm Depa Impo any i		21. Signature of Foreral Service Licensee		VŽANSKÝ GO O ROCKVILI									
	Physician				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARREST MINUTES									
	/Medical Examiner		Due to (or as a consequent		- A				1 HOUR					
	t ad	Medical Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury		A				½ HOUR					
<u>,</u>	execute and al-trans		c. Due to (or as a consequent problem)	ice of):										
68760,	rificate be executed ng physician and as the burial-transit	d												
P.O. Box 6	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year						
Records, P	quires that n signed t uld be deta	by	Part II. Other significant conditions contributing to death but not resulting ATRIAL FIBRILLATION , BREAST CAN		derlying cause given in	n Part I.			to the cause of death? Probably 4 Unknown					
eco	law requir as been si 2 should	Completed	NON HODGKIN LYMPHOMA				24a. Was ar		autopsy findings available of completion of cause of					
	n: The ficate h r, page		RENAL CELL CARCINOMA, END STAGE	RENAL	DISEASE		perform	ned? death'						
Ž	Physicien: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 ER	/Outpatient		 Place of Death Nursing Horn 		e) ince 6 □Other <i>(Sp</i>	necify)					
Division of Vital	ding J. After fune	atlon; T		b. Time of Injury	28c. Injury at Work?			w injury occurred	cony)					
Divis	르름드	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home building, etc. (Specify)	, farm, stre	et, factory, office	2	8f. Location (Str City or Town	reet and Number or I , State)	Rural Route Number,					
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle- 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the time, o estigation, in my opinio	date and place, a on, death occurre	nd due to the ca d at the time, da	use(s) and manner a ate and place, and do	as stated. ue to the cause(s)					
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License nu	ımber	29	9d. Date signed (Mor	nth, Day, Year)					
	6		E. P. Zebré		D094	476	(OCTOBER 22	2, 2004					
			30. Name and address of person who completed cause of death (Item 23 E. P. LIBRE MD 10901 CONNECT			INGTON.	MD 2089	1						
	Sta Registr	- 1	31. Date filed (Month, Day, Year) OCT 26 2004 32. Registrar's Signature		Sporks			Alvers	****					

State of Maryland / Department of Health and Mental Hygien () 1 - State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician October 27, 2004 Catherine Irene Besemer 2:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 263 Longford Drive Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Birthplace (State or Foreign
Country) 1 □ M 2 1 F Days Hours 216-22-1803 76 Yrs. Director 18, 1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygleno. An it is filem 27 le narked other than "natural", or Itame 23a or 28e-1 show ury or other traumatic svent. It is Medical Examinar must be notified at ury or other traumatic svent. The Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 1 XYes 2 ☐ No Funeral Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 263 Longford Drive 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21X No White Specify: Completed by Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey R. Showe Hattie M. Harris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: It item 27 le any injury or other trai <u>once</u>. Arthur R. Besemer / Husband 263 Longford Drive; Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 28. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 2004 Resthaven Crematory Frederick, Maryland 21. Signature of Funeral Service License Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Res Physician piratory /Medical Due to (or as a consequence of)! Examiner una Cance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ icate has been sig 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificate 1 TYAS Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Alatural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) δ 4 Homicide within 24 hours a To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 28 2004 Registrar

	Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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			1 - State Ragistrar	te of Maryland / Depa	artment of Health and Martificate of Death	lental Hygie Reg.		35664	
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Betty Collins Br	eeding		2. Date of Death Month OCT	[™] 27 2004	3. Time of Death 0800 AM	
1	Examir		4a. Facility Name (If not institution, give street a Memorial Hosp:		4b. City, Town, or Location of Death Easton		4c. County of Death Talbot		
	Funeral Director	allende	5. Social Security Number 218-30-1692 6. Sex 1 ☐ M 2	7. Age (In yrs. last birthday) 70 Yrs.	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 23,	9. Birthp Court 1933 Mar	lace (State or Foreign try) yland	
	Maryland -f show	tor	Usual Residence of Decedent	10c. City, Town or Lo				0d. Inside City Limits 1 ☐ Yes 2 No	
	with the	Direc	10e. Street and Number 4910 American Co	rner Road	10f. Zip Code 21632		Citizen of What Cour	•	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is merked other than "neturel", or Items 23a or 28a-f show myt injury or other traumatic avent, Tra Madical Examitation in utilitied at once.	Completed by Funeral Director	11. Marital Status 12. Wa Am 1 Never Married 2 Married 1 H Y	s Decedent Ever in U.S. 13. ned Forces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🌠 No Specify:		14. Race - Americ Black, White, Specify: Whi	an Indian, etc.	
21215-0036	sd within 72 ho giene. er then *netur i, I're Medical.	ompleted	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) 1 2 Co	lege (1-4or 5+) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ore Owner	ing 16b	. Kind of Business/Inc		
Maryland	ould be file Mental Hyg arkad othe atic avent,	To Be C	17. Father's Name (First, Middle, Last) Perry E. Collins		Anna	Boevers			
	and 2 sho lath and 127 is m er traum		19a. Informant's Name/Relationship (Type, Pri Diane Mowbray/Dau	ghter 4910	ng Address <i>(Street and Number or Rur.</i>) American Corn	al Route Number, Cit er Rd., F	ty or Town, State, Zip 'ederalsb	urg,MD	
Baltimore,	Pages 1 ar nent of Hea nnt: If itam 3 ury or other	1	20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Remova 1 □ Donation 5 □ Other (Specify)	I II DIII State	sition (Name of natory or other place) Order Cem. 10/3		Location - City or To		
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No.	Pnysician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	s that caused the death. Do not ent e on each line. Addo/Juluu	111016			Approximate Interval Between Oncet and Death	
	Examiner	L		Due to (or as a consequence of): Out to (or as a consequence of):	ten disease	>		418	
8760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):	/			I.	
P.O. Box 68	requires that the death certifics een signed by the attending pl hould be detached for use as t	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year	
	w requires that been signed b should be delt		Part II. Other significant conditions contributing	ng to death but not resulting in the u Carluma	nderlying cause given in Part I.	23e. Did tobacc	2 170 3 Prob	e cause of death? ably 4 []Unknown	
Il Records,	The law ate has b page 2 s	Completed by			···	24a. Was an autopsy performed 1 Yes 2	prior to con death?	osy findings available inpletion of cause of	
on of Vital	Attanding Physician: Thr death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examinar? 1 Yes 2 No Hospita 27. Manner of Death 1 Actural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year)	t 3 DOA Other: 4 Nursing Ho	h (Check only one) me 5 ☐ Residence 28d. Describe how in	6 ☐ Other (Specify)	
Division	To the Hospital or Attanding Ph within 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral	Certification:	a Could not be	Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,	
	ne Hospit n 24 hour: na Funera	Medical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death the basis of examination and/or in d manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier SN	um	29c. License number	29d.	Date signed (Month, I	Day, Year)	
			30. Name and address of person who complete David H. Smith 2	9466 Pintail I	Or., Ste 5, Eas	ton, MD	21601		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature	KI.				

			1- State of Maryland / Dep	partment of Fertificate of			ene 0	04	35665		
			Decedent's Name (First, Middle, Last)			2. Date of Death Month		Vaar	3. Time of Death		
	Physici /Medic		MICHEL W. CRAIG			OCTOBER	13	2004	12:15P ^M		
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o		ath	4c. Coun	ty of Death			
			WILLIAM HILL MANOR		TON If Under 24 Hr			TALBO			
u	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days	Hours Mir		Year)	9. Birthp	lace (State or Foreign Inc.) NOIS		
			Usual Residence of Decedent			DEC 0 13	72	11111	-NOTS		
	yland		10a. State 10b. County 10c. City, Town or	Location				1	0d. Inside City Limits		
	B Mar	ctor	MD TALBOT OXFOR	SD.					1 XYes 2 No		
	or 28	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of		itry?		
	ath w	rai	204 FACTORY ST.	2165				SA			
	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. I amaked other than "natural; or items 23a or 28a-f show aumatic event, the Medical Eva⊤fractrutal be notified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ No	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- into Rican, etc.)		ace - Americ ack, White,			
920	ali, or	by F	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Spec	ify: WH]	TE		
Õ	2 hor	ted	15. Decedent's Education 16a. Dec	edent's Usual Occup	ation	1	6b. Kind of Business/Industry		dustry		
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and S		Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, M		ime)			
Maryland 21215-0036	should ind Men marke	2	JAMES Y. CRAIG 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	line Address (Chart		RANCES WII		- C	0.11		
Na	- C N N			BOX 277 0			City or Town	n, State, Zip	Code)		
ē,	Health tam 27 othar tr		20a. Method of Disposition 20b. Place of Disp	position (Name of	1.00		0c. Location	- City or To	wn, State		
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Baltimore,	permit. Pages 1 and Department of Health Important: If item 2: any njury or other tonce.			22. Name and Addre	ss of Facility	IN & NEWNA		DD / T T	TOME DA		
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ī			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line,						Approximate Interval Between		
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9	ng ph as th	Aedi	IF FEMALE								
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy	,		ī	ate of delive			
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Vital		e Cc	25. Was case referred to medical		Of Place of De		ØNo	1 🗆 Yes	2 □ No		
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0	g Phy ter thi	n: T	27. Mariner of Death 28a. Date of Injury 28b. Time	of 28c. Injury		28d. Describe hov			,		
<u> </u>	sndin ath. or: Aft he fur	atio	2 Accident investigation		Yes 2 □ No						
Division of	or Atta	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (Stree City or Town,		ber or Rural	Route Number,		
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	To the Hospital or Attanding Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	o the	Med	and manner stated. 29b. Signature and title of contifier.	29c. License	e number	29	d. Date signe	ed (Month, D	Day, Year)		
	- > - 0		In William Howard	1) D	0871	15	10/	14/00	,		
			30. Name and address of person who completed cause of death (Item 29a) Type	o, Print)	/ /		- 1	(
			WILLIAM H. WOOD JR M.D. 501 DUTCHMA	NS LANE E	ASTON, 1	MD 21601					
h	Sta		31. Date filed (Month, Day, Year) OCT 1 2 32. Registrar's Signature	,							
	Registr	ar	OCT 15 2004	ander							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 004 35666 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** October 27 2004 James Bradford Cook 9:55 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Nursing Home Caroline Denton If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex Birthplece (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 73 March 13 1931 Kansas 237-44-2970 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mantal Hygiene.
shir: If items 23 a or 28e-f show shir: If items 23a or 28e-f show and it items 23a or 28e-f show any or other traumatic event, the Madical Examt, are must be notified as any or other traumatic event, the Madical Examt, are must be notified as 1 ☐ Yes 2X No Director Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25850 Cook Lane U.S.A. 21639 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes. Give 10 € /. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1954-56 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) civil engineer 12 highways Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Esther Winans Cook Jesse Ranson Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Helms Cook/ wife PO Box 206 Greensboro, Maryland 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBuriai 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Monroe City Cemetery Nov 2, 2004 Monroe, North Carolina 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, MD 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** on carcenoma /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of). Box 68760. for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 21 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 4 Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Medicel Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title 9 D35288 10/28/04

Nashington St Zastin MD2601 and address of rson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Des of Registrar

State of Maryland / Department of Health and Mental Hygie () 35667 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** October 23, 2004 3:15 P M George Henry Caple, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Caroline Denton 101 Sunset Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 3M 2 F Yrs 93 Director 214-16-7714 June 29, 1911 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c. City. Town or Location r then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Denton Maryland Caroline Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 21629 101 Sunset Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1936 1957 filed within 72 hours after 1 TYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Military Service/Teacher US Army/Education 11 HS Grad permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked othe eny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nora Agnes Buchman George Henry Caple, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Sunset Drive, Denton, Maryland 21629 Wife Frieda P. Caple 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/27/2004 Denton, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery 22. Name and Address of Facility

Moore Funeral Home, P.A. 21. Signature of Foreral Service Licensee 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dira to for sela consequence of) Examiner The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): physician at s the burial-t Box 68760 Physiclan/Medical as the attending IF FEMALE esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 20 No page certificate 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home Hospital: 1 Yes 25 No P 1 Inpatient 2 ER/Outpatient 5 Residence 6 □Other (Specify) 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural
2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10-27-01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Sides, M.D.
31. Date filed (Month, Day, Year) 920 Market Street, Denton, Maryland 21629 3 Registrar's Signature OCT 2 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 🕻 🛭 🗓 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dingl Robert /Medical October 12,2004 1602 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital
Sex 7. Age (In yrs. last birthday) Talbot Easton
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year, July 28, 1 **Funeral** Birthplace (State or Foreign Country) 1XM 2□ F Months Days Hours 230-78-1256 48 July Virginia Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other treumetic event. The Medical Examiner must be notified at 1 Yes 2 □ No Directo Dorchester Cambridge Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 701 Race Street Apt 21613 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Enterprise Rental Elementary/Secondary (0-12) College (1-4or 5+) Driver Car permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked ofth any injury or other treumetic event. <u>900.8</u>. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Thacker Queen Carter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall E. Banks- Friend 701 Race Street Apt 415, Cambridge, Md. 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Capitol Crematory Dover, Delware 10/18/04 ¹ 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Ser 22. Name and Address of Facility Bennie Smith Funeral Home 5, 426 Dover Street, Easton, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** AIDS disease or condition resulting in death) 15 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate ba executed use as the burial-transit Causa (Discass or I that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by tl וd be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 2 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 No 1 Tes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 29a. Certifier i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier DOOS 3 25 30. Name and address of person who completed cause of death Item 23a) (Type, Print) Snieze 136 AVE Timothy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

land 21215-0036

Dingle Baltimore, Maryl

Division of Vital Records, P.O. Box 68760,

Robert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35669 State of Maryland / Department of Health and Mental Hygien 2004

	Physici /Medic Examin
-	Funeral Director
Baltimore, Maryland 21215-0036 $ n \sim 10000 \mathrm{MeV}$	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ORCs.
	Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requiras that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

n il	1. Decedent's Name (First, Middle, L	ast)		Certificate			2. Date of Death	No.	3. Time of Death	
						-	Month	Day Year		
ŀ		artin Dres		145 000	Farm and a state of		October :		7:52 A	
	4a. Facility Name (If not institution, g				Fown, or Location	of Death		4c. County of Dear		
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	Social Security Number 6.	10 M 2 T F	ge (In yrs. last bir	Yrs. Months	Days Hours	Min.	 Date of Birth (Month, Day, Ye 	ear) 9. Birt	hplace (State or Fore	
-	270–38–2937	(51	113.			June 12,1	943 0	nio	
-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location					10d. Inside City Lin	
		ester			Cambri	daa			1 □ Yes 2	
						Lage				
	10e. Street and Number			10f. Zip	Code		10g.	Citizen of What Co	untry?	
	1615 Perseus R					1613		U.S.A.		
-	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Deced	ent of Hispanic O fy Cuban, Mexica	rigin? (Spec	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit		
	1 Never Married 2 Married	I 1 TXYes 2 □	No	1 ☐ Yes 2	,	,		hite		
	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1965–67	1			Specify. **			
	15. Decedent's (Specify only highest of		16a.	Decedent's Usua (Give kind of wor	k done durina mo	st of working	16b	. Kind of Business/	Industry	
	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT us	e retired)	2				
	12	5+		psycho	logist			state hos	pital	
	17. Father's Name (First, Middle, Las	st)			18. Moth	er's Name	(First, Middle, Maid	den Sumame)		
Martin Drescher Edith Johnson										
Ì	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State									
	Joan Drescher wife 1615 Perseus Road, Cambridge, MD 216									
1	20a. Method of Disposition	Location - City or	Town, State							
I	1 ☐ Burial 2 🗷 Cremation 3	☐Removal from State	cemeter	Disposition (Namey, crematory or ot	her place)	10/22				
1	`4 □ Donation 5 □ Other (Spec		Saltsn	oury Crematory 10/22/04 Salisbury, MD 22. Name and Address of Facility Thomas Funeral Home P.A.						
ı	21. Signature of Funeral Service Lic	ensee							P.A.	
4	Drank.	Dint					bridge, N	D 21613		
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	iy one cause on each I	ne.						Approximate Interval Between	
	Immediate Cause (Final disease or condition		Accet	2 Core	chary	Syn	drome		Onset and Death	
	resulting in death)									
	Bequentially list conditions, any, leading to immediate course, End Underlying Cause (Disease or injury									
i	Cause (Disease or injury									
	at initiated events c. Due to (or as a consequence of):									
i l										
		`								
		d. =								
	IF FEMALE:	d.	of programmy							
	23b. Was decedent pregnant	d. 23c. If yes, outcome 1∐Live birth	2 Fetal death	3□Ectopic pre				23d. Date of deli		
1	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d. 23c. If yes, outcome	2 Fetal death	3 □Ectopic pre 5 □ Other (spe					very Day Year	
1	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1	2 □ Fetal death t time of death	5 ☐ Other (spe	ecify)			Month	Day Year	
1	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d. 23c. If yes, outcome 1	2 □ Fetal death t time of death	5 ☐ Other (spe	ecify)	I.		Month to use contribute to	Day Year the cause of death?	
1	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1	2 □ Fetal death t time of death	5 ☐ Other (spe	ecify)	1.	23e. Did tobacc 1 □ Yes	Month to use contribute to	Day Year the cause of death?	
1	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1	2 □ Fetal death t time of death	5 ☐ Other (spe	ecify)	I.	1 ☐ Yes	Month o use contribute to 2 No 3 F	the cause of death? bably 4 Unknow	
	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1	2 □ Fetal death t time of death	5 ☐ Other (spe	ecify)	I.	1 ☐ Yes 24a. Was an autopsy performed	Month o use contribute to 2 No 3 Pro 24b. Were au prior to codeath?	the cause of death? bbably 4 Unknotopsy findings availa ompletion of cause of	
1	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	d. 23c. If yes, outcome 1	2 □ Fetal death t time of death	5 ☐ Other (spe	use given in Part		1 Yes 24a. Was an autopsy performed 1 Yes 2	Month o use contribute to 2 No 3 Pro 24b. Were au prior to codeath?	the cause of death? bably 4 Unkno	
1	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions 25. Was case referred to medical examiner?	d. 23c. If yes, outcome 1	2	5 ☐ Other (spe	use given in Part 26. Plac	e of Death (1 Yes 24a. Was an autopsy performed 1 Yes 2 Check only one)	Month to use contribute to 2 \(\sum \) No 3 \(\sup \) Prove to contribute to contribute to 1. The contribute to 2 \(\sup \) No 1 \(\sup \) Yes	the cause of death? bably 4 Unkno topsy findings availa ompletion of cause of	
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Registrar

		1 - For State of Maryland / Department of Health Certificate of Dea		gie 2 e 0 0 4	35670				
Physici /Medic			2. Date of De. O.T. OBE		3. Time of Death 3:38A M				
Examin			ion of Death	4c. County of De	GEORGE 'S				
Funeral Director		5. Social Security Number 6. Sex 1 Months 2 TF 73 Yrs. 6. Sex 1 Months Days Hour	nder 24 Hrs. 8. Date of Birt (Month, Da MAY 25	y, Year) (irthplace (State or Foreign Country) IO				
aryland show d at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 □ No				
the Market 1:	recto	MARYLAND PRINCE GEORGE'S GREENBELT 10e. Street and Number 10f. Zip Code		10g. Citizen of What (<u> </u>				
th with 23a or	al Di	6946 HANOVER PARKWAY 20770		U.S.A.					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28e-f show eny injury or other treumatic event. In Medical Examinal must be notified at once.	by Funeral Director	3 ▼ Widowed 4 □ Divorced	xican, Puerto Rican, etc.)	- 14. Race - Am Black, Wh Specify:					
within 72 hc iene. Ithan "netur h. Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during in life. DO NOT use retired) CUSTOMER SERVICE	-	16b. Kind of Busines WHOLESALE OF HOME GO	SUPPLIER				
id be filed ental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last)	Nother's Name (First, Middle, LEN MAXINE ST	Maiden Surname)	3020				
and 2 shou ealth and M n 27 is mar ier treumat	-	19a. Informant's Name/Relationship (Type, Print) LISA A. HUNT / DAUGHTER 19b. Mailing Address (Street and Num 245 SUMNER ST., N		er, City or Town, State,	Zip Code)				
Pages 1 ar ment of Hea ent: If item: ury or other		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of Compeler Circumstance) (Name of Circumstance) (Name of Circumsta	Date 10/27/2004 1	20c. Location - City of	RYLAND				
permit. Departimport import eny inj		21. Signature of Funeral Service Licensee 22. Name and Address of Fa							
Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentiatly list bunditions if any, leading to immediate Due to (or as a consequence of):		røst,	Approximate Interval Between Onset and Death				
ficate be executed physician and is the burial-transit	Physician/Medical Examiner								
To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	alivery Day Year				
w requires that the death been signed by the atte should be detached for	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
The law re ate has be page 2 sho	Completed			an 24b. Were a prior to death?					
hysicien: this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 EP/Outpatient 3 DOA Cther: 4	Place of Death (Check only on Nursing Home 5 Resid	lence 6 □Other (Sp	ecify)				
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	27. Manner of Death 1 Natural 2	2 🗆 No	now injury occurred Street and Number or F	Jural Pouto Number				
pitel or A burs after erel Direc			City or Tow	m, State)					
thin 24 hos thin 24 hos the Fun impletely	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, of and manner stated.	death occurred at the time,	date and place, and du	e to the cause(s)				
, M 7 00	_	SAMUEL F. ASFAW, MD MDD6061:	1	10/23	104				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL F. ASFAW, MD 8118 GOOD LUCK ROAD, LANHAM, MARYLAND 20706							
Sta Registr	-	111' 3 '9 5 '700' 4 1888 a 187 18 a 187 .							
HMH 17 Pay 1/2	001				-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗓 🗓 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year C545M 10 mond 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Licenico al rasta, espice Lake 115 Decre If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 □ F 2/6 Yrs. Director Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits Item 27 is marked other then "neturel", or Items 23a or 28e-f shov other treumstic event, the Medical Examinar must be notified at Director MD Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Bellevue Ave. U.S.A. 21613 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other then "neturel", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) teacher education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Paul Jones Sarah Elizabeth Bramble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Edmondson 10 Bellevue Ave., Cambridge, MD daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State = 5 Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Old Trinity Churchyard 10/22/04 Church Creek, MD of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part / Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dealt Immediate Cause (Final **Physician** mon! disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I be detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 □Unknown 1 Tes the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 25. Was case referred to medical examiner 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes Inpatient 2 ER/Outpatient 3 □ DOA this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C 🗲 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) belALL

Registrar

DHMH 17 Rev 1/2001

State

Day, Year)

2004

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiepen 35672 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Cheryl Ann Үөаг **Physician** Eby October 26 2004 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner 44 Far Corners Loop Sparks Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 1 □ F Yrs 219-54-2694 Director 10. 1952 Baltimore Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ad other than "natural", or Itams 23a or 28a-f ahow evant, the Medical Expresse must be redified at MD Baltimore Upperco 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4421 Black Rock Road 21155 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the compared to the 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygienn Important: If Itam 27 Ia marked other the any injury or other traumatic event, Itam 2008. 4 Program Assistant Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Phyllis Dries ٥ Wayne D. Fedely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Far Corners Loop, Sparks, MD 21152 of Disposition (Name of Disposition (Name of Disposition Characteristics) John S. Eby Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Cremations, Inc. 10/27/04 Hampstead, MD [↑] 4 □ Donation 5 Other (Specify) Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a Part 1. Enter-the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Heart ongestive Several yrs disease or condition resulting in death) /Medical Due to (or consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physiclan/Medical Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 🗌 Yes 2 No of Vital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death Check onl one Husband's examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Rother (Specify) | Residence Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 29a. Certifier 🛮 🕊 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hc To the Fun completely 1 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) D0036112 10-26-04 1081 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Alexander Rocha, M.D. 4231 Northwoods Trail, Hampstead, MD 21074 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DUT 27 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen [] 35673 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month October 1247 13 2004 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Easton the Memorial Talbot pita Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, OCT. 15, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕱 F Months NORTH CAROLINA Yrs. 241-52-9016 65 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 X No HURLOCK DORCHESTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21643 USA 6904 QUAIL RUN DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify. 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING ASSEMBLY LINE WORKER 10 -0-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LILLIAN McDONALD "IJNKNOWN" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 162 DUNDEE ROAD, SEVERNA PARK, MD 21146 THERESA L. RILEY/ DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEAKE CREMATION 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-15-2004 STEVENSVILLE, MD 1 4 ☐ Donation 5 ☐ Other (Specify) CENTER, L.L.C

Pnysician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Direct

Funeral

þ

Completed

Be

Funeral

Director

23s or 28s-1 show

injury or other traumatic event, the Medical Exentrac must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene in Institute in Item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Medical Example ones.

Baltimore, Maryland 21215-0036

with the Maryland

After within 24 hours a To the Funeral C

Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Liosoph M. Osta	eash C.F.S.P.	FELLOWS, HELFENBEIN 200 S. HARRISON ST	& NEWNAM F	UNERAL H MD 21601	OME, P.A.				
	23a. Part1. Enter the disease, or complishock, or heart failure. List only or transdiate Cause (Final disease or condition resulting in death)	ne cause on each line. a Hypovoler	at enter the mode of dying, such as cardiac			Approximate Interval Between Opset and Death Hours				
ical Evalinici	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Coag wlopathy Due to (or as a consequence of): Coag wlopathy Due to (or as a consequence of):									
in a second seco	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of deli Month	elivery Day Year							
. (====================================	Parl II. Other significant conditions con Breast (Acute no	Parcinoma	the underlying cause given in Part I.	23e. Did tobacco	2 No 3 Pro	the cause of death? bbably 4 Unknown topsy findings available completion of cause of				
1	25. Was case referred to medical examiner?	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
	1 Yes 2 No 27 Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 2 □ ER/Outp 28b. Tir	o 6 □Other (Specify) nitury occurred							
	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	28f. Location (Street a City or Town, Sta	(Street and Number or Rural Route Number, own, State)						
	29a. Certifier (Check only one) Check o									
	29b. Signature and title of certifier	Stout, M.D.	29c. License number 0 0 680 4		Date signed (Month, Day, Year)					
	30. Name and address of person who co		S, westingen-	St East	on, mt	21601				

State Registrar

Varic 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien 👂 🛭 🗓 👢 35674 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 27, 2004 **Physician** Jack W. Fritz 4:47 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 28 East Orndorf Drive Frederick Brunswick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 26, 1 5. Social Security Number 6. Sex 1 AM 2 ☐ F 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Min Yrs 75 Ĩ/928 218-24-1441 Nov. Maryland Director Usual Residence of Decedent death with the Maryland ehow. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23a or 28a-f ehov other traumatic event, I'm Medical Examinatinast to notified at 1 XYes 2 No Director Frederick Brunswick Maryland 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 28 East Orndorf Drive 21716 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c. Depriment of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or Item any injury or other traumatic event, the Mental Once. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: White Be Completed by Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Deck Attendant City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William M. Fritz Margaret E. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Palmer / Daughter 2446 Forest Drive #202, Woodbridge, IL. 60517 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Nov. 1,2004 Frederick, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21716 Part: Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac anest /Medical Due to (or as a consequence of): **Examiner** Responsibility Falure Mikinter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed emmed com Due to (or as a consequence of) of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy fo in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 ☐ Yes 2 No Physicien: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Division 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Hospital 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WV 21279 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Tracy Cly/N Registra s Signature 31. Date filed (Month, Day, Year) State 5 MOA Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:41A M Ε. October 22, Marjorie Gi11 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 94 Yrs. **Director** 577-16-9300 March 31,1910 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be nutified at other. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Director D.C. Washington none 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 2624 Moreland Place, N.W. 20015 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry D.C. Elementary College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kate Coggins Frank McDonough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Cavanaugh/Daughter 3517 Mullin Lane Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct.26, ry 2004 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Md. 21. Signature of Euneral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 20007 Mune) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4114 019 25 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy After this certificate ZIZINO 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 2 ER/Outpatient 3□ DQA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Qural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filod (Month, Day, Year) 32 Registrar's Signature State 26 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 200 35676 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 OCTOBER. 1955 PAUL JOHNSON HEISTER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** EASTON TALBOT TALBOT HOSPICE HOUSE If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1X M 2□ F Yrs. 91 MAR 21 1913 WASHINGTON D.C. **Director** 577-10-5495 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location r then "natural", or items 23a or 28e-f show the Modical Examiner must be notified at 1X Yes 2 □ No Director EASTON TALBOT MD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21601 4102 700 PORT ST., APT. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT 12 BOAT CAPTAIN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H lent: If item 27 Is marked ott STELLA WILIKE MICHAEL HEISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 700 PORT ST. APT 4102 EASTON, MD 21601 CLAIRE C. HEISTER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 10-21-2004 OXFORD, MARYLAND OXFORD CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 200 S. HARRISON ST EASTON, MD 21601 Ostrowski C.F.S.P. Coseph M. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Due to (or as a consequence of): PRUTE 3 W64/1 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and if for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes or Attending Physician: Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE After the 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after deal To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUDWIG J/. EGLSEDER III M.D. 503 IDLEWILD AVE EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State I Z Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 35677 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year HOLLAND 11:18 AM JOHN OCTOBER 09 2004 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 ☐ F Days Hours 69 Yrs 214-30-9549 29. 1934 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Kent Chestertown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21620 USA 525 Roundtop Road 12. Was Decedent Ever in U.S.
Amed Forces? 22—May
1 X) Yes 2□No 1957
If Yes, Give
Year or Dates: 12→3-57 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status

1 ☐ Yes 2 No

Caretaker

20b. Place of Disposition (Name of cometery, crematory or other place)
Eastern Shore

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify: Black

Private Families

20c. Location - City or Town, State (Beulah)

OCTOBER

BALTIMORE, MD

09

21201

2004

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

Mary Velbale

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Roundtop Road, Chestertown, Maryland 21620

Maryland Veterans Ce Oct. 11, 2004 Hurlock, Maryland

22. Name and Address of Facility Bennie Smith Funeral Home

with the Maryland item 27 la marked other than "natural", or Itema 23a or 28e-f show other traumatic event, the Neuloul Exertainst must be invitibed at filed within 72 hours after death Baltimore, Maryland 21215-0036 Il Hygiene. permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other traumatic event

Physician

/Medical

Examiner

10a. State

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

McCount uno

13 200

RYAN MCCOPYMACK

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

College (1-4or 5+)

3XXWidowed 4 □ Divorced

Elementary/Secondary (0-12)

Floyd Holland

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

Marjoria F. Johnson

* 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee

11th

Director

Funeral

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Completed

Be

Funeral

Director

Physician /Medical Examiner

OUCe.

Examiner

Physician/Medical

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Completed

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Certification:

anding physicien and use as the burial-transit The law requires that the death certificate be executed for detached δ 90 certificate has been page or Attending Physician: funeral director, this After after death. the 1 in by t

P.O. Box 68760,

Division of Vital Records,

426 Dover Street, Easton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL ACUTE FAILURE 4 DAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last I SCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): CORONARY ARTERY DISEASE 1 YEAR Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

13112

State Registrar

DHMH 17 Rev 1/2001

within 24 hours a To the Funerel I filled

To the

completely

22 SOUTH GREENE ST.

		1	For State Registrar	te of Maryland / Department	artment of He			ene 2001	35678
	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Raymond Hotch	kiss			Date of Death Month October	Day 2004	3. Time of Death 4:10 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street a		4b. City, Town, or L			4c. County of Death	
			18 Old Elm Court		Lutherv			Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 1	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, YApril 12	(ear) 1918 Ne	nplace (State or Foreign untry) W York
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	Maryland Baltimore	Lutherv	ille				1√ Yes 2 No
	vith th	Dire	10e. Street and Number		10f. Zip Code 21093			j. Citizen of What Cou J. S. A.	untry?
	eath v	erai	18 Old Elm Court 11. Marital Status 12. Wa	s Decedent Ever in U.S. 13.		panic Origin? (Speci		14. Race - Amer	ican Indian,
36	be tiled within 72 hours atter death with the Maryland tal Hygiene. id other than "naturel", or Items 23a or 28a-f show deent, the Medical Evaniral must be incitified at	by Funeral Director	1 ☐ Never Married 2 Married 1 M	ned Forces?]Yes 2 □ No Navy es, Give ar or Dates: WW 2	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☒ No	Mexican, Puerto Ric Specify:	ćan, etc.)	Black, White Specify: Whi	
21215-0036	72 hor	eted	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Dece	dent's Usual Occupat kind of work done du DO NDT use retired)	ion iring most of working	16	6b. Kind of Business/I	ndustry
121	within ene. than "	Completed	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	DO NDT use retired) Engineer			J. S. Gove	rnment
d 2	e tiled within It Hygiene. other than vent, the Me		17. Father's Name (First, Middle, Last)	lears		18. Mother's Name (i			- I I I I I I I I I I I I I I I I I I I
/lan	should be t nd Mental h marked of	To Be	Louis Hotchkiss			Mary St	eckler_		
, Maryland	permit. Pages I and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any injury or other treumatic evonce.		19a. Informant's Name/Relationship (Type, Pri Evelyn Hotchkiss — Wi		ing Address <i>(Str</i> eet a <i>r</i> 1d E1m Cou				ip Code) 21093
Baltimore,	of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Remova		matory or other place			c. Location - City or	
ţ	tment tent:		* 4 □ Donation 5 □ Other (Specify)	King Dav					ch, Virginia
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	allemyer	^{2. Name and Address} anzansky-G 170 Rockvi	lle Pike,	Rockvil	lle, Maryl	and 20852
	Physician //Medical Examiner phujar-transit		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	se on each line.		, such as cardiac or i	espiratory arres	t.	Approximate Interval Between Onset and Death
			resulting in death)	Congestive Heart Oue to (or as a consequence of):	rallure				
				oue to (or as a consequence or).					
		ner	cause. Enter Underlying	Due to (or as a consequence of):					
		Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):						
60,	be ex sician burial	icai E		sac to (or as a consequence or).					
68760,	iticate t g physia as the b		d						
O. Box	it the death certiticate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
0	uires that the signed by Id be detacted	b	Part II. Other significant conditions contribution	ng to death but not resulting in the	underlying cause give	n in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed					24a. Was an autopsy performe	prior to o death?	topsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical examiner?			26. Place of Death (
of V	dis y	To B	1 ☐ Yes 2 X No	1 Inpatient 2 EH/Outpatie				ce 6 □Other (Spec	cify)
		ion:	1 X Natural 5 ☐ Pending	. Date of Injury (Month, Day Year) 28b. Time Injury	Work	at 28 ? es 2 □ No	d. Describe how	injury occurred	
Division	or Attender death irector:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 286	b. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Atten within 24 hours atter deat To the Funerel Director: completely filled in by the	Medical C	(Check only 2 Medical Examiner: 0	To the best of my knowledge, dean the basis of examination and/or individual manner stated.	th occurred at the time nvestigation, in my op	e, date and place, an inion, death occurred	d due to the cau I at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comple	⊠	29b. Signature and title of certifier	1	29c. License	number	290	d. Date signed (Month	n, Day, Year)
	-		Marc No	2dely up	D 26	835		10/20/2004	
	5		30. Name and address of person who complet Paul Valle, M. D. 656	//		e 216, Ba	ltimore	, Md. 2120	4
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 6 2004	32. Registrar's Signature	Sparker	/			
	negist	T Call	UU 1 20 2004	/	11				

			For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of He rtificate of D	ealth and M <i>eath</i>		iene 2 ()	04	35679
	Physici		1. Decedent's Name (First, Middle, Las	tley, Jr.				2. Date of Deal October	h	64	3. Time of Death 6:25P. M
ì	/Medic Examir		4a. Facility Name (If not institution, give Laurel Regional H	ocation of Death			. County of Death Prince George's				
	Funeral Director		5. Social Security Number 6. Se 213–38–3928	7. Age (In yrs. la XM 2 F		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June3, 1	^{Year)} 942	9. Birthpl Count Mary	
	Aaryland F show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2 ☆No
	with the had or 28a-i	Direct	10e. Street and Number 12700 Old Gunpowd			10f. Zip Code 20705		1	Og. Citizen of W		•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic event, the Madical Examiner must be inclifted at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Amed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🂢 No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- America k, White, c	
Maryland 21215-0036	within 72 hor ene. than "natura he Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)		completed) (Give kind of work done during life. DO NOT use retired)				U.S.D.A	ustry	
land 2	uld be fited lental Hygi rked other	To Be Co	17. Father's Name (First, Middle, Last) William H. Heartl	ey, Sr.			I8. Mother's Name Icie	(First, Middle, I	Maiden Sumam	Cros	on
Mary	ind 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship (7 David A. Heartley		19b. Mailii 4910	ng Address (Street ar Talbot Av	enue Bel	tsville,	City or Town, Maryla	State, Zip and 2	Code) 0705
Baltimore,	Pages 1 and of He int: If item		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Removal from State For	ace of Dispo emetery, crea Line	osition (Name of matory or other place COIN Cemet			20c. Location - Brentwo	•	wn, State Maryland
Balt	permit. Departition function f		21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or compshock, or heart failure. List only	Browny	44	2. Name and Address DNAID V. B 400 Powder ter the mode of dying,	Mill Ro	ad Belts	sville.	P.A. Marv	land 20705 Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Anoxic En		lopathy					
- 62		ner	Sequentially list conditions, in any leading to immediate gause. Enter Underlying	Due to or as a consequ	ence of:	rt Failure					
8760,	icate be executed physician and s the burial-transit	Medical Exam	Cause (Disease or injury that initiated events resulting in death) Last	c. Coronary Due to (or as a consequence)		y Disease					
Box 6	the death certify the attending ched for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	tal death 3 Ectopic pregnancy Month Day						·
ds, P	Se Ded	þ	Part II, Other significant conditions contributing to death but not resulting in the bilderlying cause given in rates.							ibute to th	_
Records	e law has b	Completed						24a. Was a autops perform	megel? d	Vere autor rior to con eath?	osy findings available npletion of cause of
Vital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical 26. Place of Death (Check only one)								
of	ing Phys After this uneral di	tlon: To	1 Yes 2 To 27. Manner of Death Ratural 5 Pending 2 Accident investigation	Hospital: 1 Date of Injury (Month, Day Yeer)	28b. Time of 28c. Injury at 28d. Describe how injury occur)
Division	or Atten after deat Diractor: in by the	Certification:	3 Suicide 6 Could not be determined	286 Ocation (Street					eet and Number or Rural Route Number, State)		
	pspital hours a uneral I	aC	29a. Certifier Certifying Ph	ysician: To the best of my kno	wledge, deal	th occurred at the time	e, date and place,	and due to the c	ause(s) and ma	nner as st	ated.

Medic

State Registrar

29b. Signature and the of certified

31. Date filed (Month, Day, Year) 32. F

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2.4CJ

State of Maryland / Department of Health and Mental Hygiene \(\cap \)

35680

					Cei	rtificate	of E	Death			Reg. No.	UH	JUI	000	
	Dhuminian								Date of Deeth Month Dey Year			3. Time o	f Death		
h.,	Physician /Medical		RAYMO	ND THO	OMAS	HOOD				OCT.		004	8:00	6 PM	
Ì	Examiner	4e Fecility Neme (If not institution		•						cation of Dee	, , , , , , , , , , , , , , , , , , , ,				
		WESTMINSTER				If Lindor 1		WEST							
	Funeral	5. Social Security Number 214-28-5646	6. Sex 7.	Age (In yrs. ia. 74	st birthdey) Yrs.	If Under 1 Y Months D	ays	If Under:	Min.	8. Date of B (Month, D	rth ay, Yeer)		lace (State of	or Foreign	
	Director	Usuel Residence of Decedent		7 -						1/9/	1930	MARY	LAND		
	show	10a. State 10b. County		10c. City,	Town or Lo	cation					***	1	0d. Inside C	ity Limits	
	Mary Mary	MD. C.	ARROLL	NI	EW WI	NDSOR							1 ☐ Yes	Ž(☐ No	
	1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10e. Street end Number				10f. Zip Co	de				10g. Citizen of	Whet Cour	ntry?		
	within 72 hours after death with the Marylend ena. Than "netural", or items 23a or 28a-f show he Medical Examiner must be notified at he more an an included an implementation of the contraction.	1108 WINTER	S CHURCH	RD.		21	776	5			USA				
	r dea	11. Marital Status	12. Was Decede Armed Force	es?		Was Decedent	t of His Cuben	panic Orig	gin? (Spe	cify Yes or N		ce - Americ			
20	safte , or h y Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	If Van Chia	□ № KORI sCONFL	1	1□ Yes 2☐	K _{No}	Specify:				ήν: WH			
215-0020	bour bour		t's Education	SCONFL		dent's Usual O	looupat	lion							
5	be filed within 72 hor tel Hygiena. d other than "natura event, the Medical Be Completed	(Specify only higher	st grede completed)		(Give	kind of work d DO NOT use re	lone du etired)	<i>ring</i> most	t of workir	ng	160. Kind of E	ind of Business/Industry			
212		Elementary/Secondary (0-12)	College (1-4	or 5+)		HINE C					SHOE FACTORY				
ᄝ	ent.	17. Fether's Neme (First, Middle,	Last)				1	18. Mothe	r's Name	(First, Middle	, Maiden Surna	me)			
<u>a</u>	should be filed and Mentel Hygi marked other imatic event, I To Be Cc		WILBUR 7	rhomas	HOO	D		N	1ARI	E GER	TRUDE	BARB!	ER		
Maryland	and Rand Rand Rand	19a. Informant's Name/Relations	ship (Type, Print)								er, City or Town		. — .		
	and 2 aaith n 27 i	ROBERT L. HOC	DD -BROTH					CHU	JRCH	RD.,	NEW WI			•	
<u>e</u>	or oth	20a. Method of Disposition	3 □ Removal from Sta	20b. Pla	ce of Dispo netery, cren	sition (Name on natory or other	of r place,)		Date	20c. Location	•			
altimore,	Pe it j	1 M Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	pecify)	WESLI					1		4 ELDI		•	MD.	
ga	parmit. Departn importa any inju	21. Signature of Funeral Service	Licensee	/	//						RFUNER				
	0D 2 6 0	1 Lary	led to	als	25	04 E.	MAJ	LN S	T., V	/ESTM.	INSTER,	MD.	2115	5 /	
		23a. Part1. Enter the disease, or shock, or heart allure. List	complications that our only one ceuse on each	sed the death. h line.	Do not ent	er the mode of	dying,	such as	cardiac o	r respiratory a	irrest,		Approximate	ween	
) F	Physician	land the Court (Find		· ·				-				!	Onset and I	Death	
	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	a. M	clasta	tre	Colo	77	Con	ne	_		j	5m	<u></u>	
	ē 1			Due to (or a	as e conseq	uence of):						1			
	uted d ansit	On a second line line and divine	b	Due to (or e	NE 0 000000	uance of):						ĺ			
ລົ	t be executed sician and burial-transit	if eny, leading to immediate ceuse. Enter Underlying		Due 10 (01 e	s a conseq	derice oi).									
Due to (or es a consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that inititeded events resulting in death) Last Due to (or es a consequence of):															
ž ×	entifica ding ph sa as th	resulting in death) Last	L.									j			
\sim	v requires that the death certifue been signed by the attanding should be detached for usa a leted by Physician/Me		d												
- -	at the death of by the attancatached for us Physician	Part II. Other significant condition	ons contributing to death	but not resulti	ing in the ur	nderlying cause	e given	in Part I.		23b. Did	tobacco use co	ontribute to	the cause o	of death?	
7. O	d by									10	Yes 2 No	3□ Prot	ably 4	Unknown	
cords,	requires that seen signed b hould be date eted by PI									04- 111-		24h W		in dia na	
Ö	requ										an autopsy ormed?	ava	re autopsy f illable prior to npletion of co leath?	0 ~	
Φ.	? (A) (A)									00,000		of c	leath?		
	certificate har irector, page 2	05 W								10		1	lYes 2□	No	
= =	Thysician: this certificral director, TO Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	ACIE	2/0-44	. all pos	Other			(Check only					
	E E E	27. Manner of Death	28a. Date of Ir	njury 2	NOutpatien 8b. Time of		Injury a Work?				dence 6 Dott)	-	
0	th. After a funer	1 Natural 5 ☐ Pendin 2 Accident investig	9	Dey Year)	Injury			es 2□N	No		, ,				
UIVISION	Attending Physical Attention of the funeral by the funeral offication:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	of be 28e. Place of Injury - At home, farm, street, factory, office				fice 28f. Location (Str			Street and Numi	treet and Number or Rurel Route Number,				
5 .	tal or Attending P is after death. In Director: After ted in by the funers Certification:	4 Homicide	building,	etc."(Specify)						City or To	WII, Stelle)				
	hour hour hour hour hour hour hour hour	29a. Certifier 12 Certifyin	g Physician: To the bes Examiner: On the basis	st of my knowle	edge, death	occurred at th	e time	, date and	place, a	nd due to the	cause(s) and m	anner as st	ated.		
,	To the Hospital or Attends within 24 hours affector: A To the Funeral Director: A completely filled in by the fi Medical Certificati	one)	and menner	stated.	. and of the				0000118	. at the time,				,	
		29b. Signature and title of certifier	1	10-6		29c. Lic			2		29d. Date signe				
	MILA	John W	mile				שע	2544	J		10/2	5/2	204		
	1/1/W	30. Neme and address of person						ים הודים	H11/47-v-	CHITTO					
	Clus [*]	JOHN W. MIDD. 31. Date filed (Month, Day, Year)	LETON, M.D	ntrar's Signatur		LE RD	• ,	WES	T 1.1 T T/	SIEK,	MD. 2	11157			
	State Registrar		6 2004	her.	K.	Somet.									
			-		~ /9	The same									

State of Maryland / Department of Health and Mental Hygien 35681 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Dorothy Louise Hammer October 2004 9:50 pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Caroline Denton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye July 8 1 Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🛛 F Yrs. 90 Maryland Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Caroline Greensboro 10f. Zip Code 10g. Citizen of What Country? 14071 River Road 21639 **USA** 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2ᡚ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William B. Jump Florence E. Johnson Jump 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Nancy Hammer/ daughter 2616 Fairhope Road Wilmington, Delaware 19804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 10/26/04 Greensboro, Maryland 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA 21. Signature of Funeral Service Licensee PO Box 160 Greensboro, MD 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. eart Failure

Physician Madical Examiner Physician/Medical Examiner

Hospital or Attanding Physician: The law requiras that tha death certificete be exacuted

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Be Completed

edical Certification: To

: Aftar this a funaral

erai Director: Af

r death.

within 24 hours after To the Funeral Dire

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

5. Social Security Number

10a. State

Maryland 10e. Street and Number

11. Marital Status

11- grad

20a. Method of Disposition

Directo

Completed by Funeral

217-76-1618

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

Due to (or es a consequence of)

Due to (or es e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

INSUFFICIENCE

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed?

26. Place of Death (Check only one)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

25.	Was case examiner? 1 Yes	 to medical
27.	Manner of	5 □ Pending

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Dey Year) investigation

3□ DOA 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Volunising Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investination in my calculated and the cause of examination and/or investination. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

29d. Date signed (Month, Dey, Yeer)

30. Name and address of person who completed cause of death (Item 23a) (Type,

2004

5

6 Could not be determined

32, Registrar's Signature

State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registral 35682 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1735 Kathleen Norris Kimbrell Oct. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 ☐ M 2 🕱 F Yrs. 78 Director 057-18-1259 Nov. 25,1925 CA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Severna Park 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 213 McKeon Road 21146 USA or Itema 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married ☐ Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Homemaker **Home** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Olcott Davis Ethel Marie Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Dawn Kimbrell/Daughter 213 McKeon Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct. 26, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Annapolis, MD Hillcrest Cemetery 5 Other (Specify) 4 Donation 2004 21. Fignature Fineral Service License Barrancodo Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Paft1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death w not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician (-Uninio doys /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The taw requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the SS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan has autopsy 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No 1 🗷 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: : After 5 Pending investigation 1 Matural death. hours after death.
uneral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a)-(Type,/Print) 600 gistrar's Signature 31. Date filed (Month, Day State

Registrar

2 5 2004

		For State Registrar/AMEND#29dperMD				rtment e tificate	of Healt <i>of Dea</i>	h and M <i>th</i>	lental Hyg	ien 2 () ()	14 35683	}
Physicia /Medica		1. Decedent's Name (First, Middle, Last,			iter				2. Date of Deat Month.	Day 36	Year 2004 19:15 M	Л
Examine		4a. Facility Name (If not institution, give HOW CVU Commy		url H	ospital		CO/L	on of Death	in	4c. County	of Death	
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Maryland f show	jo	Usual Residence of Decedent 10a. State 10b. County Maryland Howard		10c. City	, Town or Loc						10d. Inside City Limits	
with the I	Funeral Director	10e. Street and Number 4994 Beaverbrook I	Road			10f. Zip C	21044		11	og. Citizen of W United		
ba filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or Itams 23a or 28a-1 show event, the Medical Exament must be notified at	by Funera	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give	es? XNo	If	⊿s Deceder Yes, specify	Cuban, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. White	
hin 72 hour	Completed	15. Decedent's Edu (Specify only highest grad	Year or Dat cation e completed) College (1-4			ind of work O NOT use	doné during r retired)	nost of worki	ng	16b. Kind of Bu	siness/Industry	
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d 2 should th and Mer t7 is mark traumatic	0	19a. Informant's Name/Relationship (Ty Kenneth A. Lechter							Noute Number, kville,			
permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked any injury gr other traumatic en		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from St	l ce	lace of Dispos emetery, crem Leban	atory or other	ar place)	i			City or Town, State Maryland	
permit. Departm Importa any inju		21. Signature of Funeral Service Licens	ngu	andt	- Do:	Name and A nald V 00 Pow	Address of Fa 7. Bor waer M	wardt ill Ro	Funeral ad Belts	Home,	P.A. Maryland 2070	15
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/Medical Examiner		resulting in death) Sequentially list conditions,	o	r as a consequ c r as a consequ	17		8h vsión					
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Hospital 24 hours a Funaral E	edical Ce	29a. Certifier (Check only one) (Check only one) (Check only one)	sician: To the b	sis of examinat	wledge, death ion and/or inve	occurred at estigation, in	the time, date my opinion,	and place, a	and due to the ca ed at the time, da	use(s) and mar te and place, a	nner as stated. nd due to the cause(s)	-
Within 7 To the Comple	Me	29b. Signature and title of certifier	_ no	-		29c. L	icense numb	er 70	29	d. Date signed	(Month, Day, Year) 2004 L 24Th 2003	-
10		30. Name and address of person who co	ompleted cause	of death (Item	23a) (Type, P	Print) Sel	l lav	ne C	larles	alle	MD 2 (029)	
State Registra		31. Date filed (Month, Day, Year) OCT 26 206	32. Re	gistrar's Signat	ture &	Span	Kn					

State of Maryland / Department of Health and Mental Hygie e 1 35684 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rivka Lubetzky Year October 23, 2004 6:30 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1401 Blair Mill Road Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 M 2 T) F Months Yrs. Director 062-34-2446 86 July 27, 1918 Japan Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral', or items 23s or 28s-f show Examiner rust be notified at 10d. Inside City Limits New York Bronx Bronx 1X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 140-11 Einstein Loop North 10475 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iten any injury or other traumatic event, the Medical Examinations. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ₩idowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Comptometer Operator Various 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fainberg ၉ Smallen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Lubetzky / Daughter 1401 Blair Mill Road, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Montifiore Cemetery 10/25/2004 4 □ Donation 5 □ Other (Specify) Queens, New York 21. Signature of Funeral Service Lie 22. Name and Address of Facility Castle Hill Funeral Directors, M00956 1528 Castle Hill Ave., Bronx, NY 10462 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MULTI-INFARCT DEMENTIA /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) death certificate be executed the attending physician and hed for use as the burial-tran DIABETES MELLITUS II that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 1 Yes 2 🗆 No 2**X** No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence SX Residence of Other (Specify Daughter Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 X No funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending After 5 Pending investigation 1 X Natural within 24 hours after death.
To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier ļ 29c. License number 29d. Date signed (Month, Day, Year) 047928 10/23/04 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila M. Bahadori, M.D., 10301 Georgia Ave., #304, Silver Spring, Maryland 20902

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 26 2004

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3. Registrar's Signature

Amend item#29a, perDVR, G637, 11/10/04 11
State of Maryland / Department of Health and Mental Hygiene 2001. 35685 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 1650pm OMBARD 10 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wursing Home Northhampton rederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 X F Yrs. April 8, 1910 Massachusetts 94 577-60-4471 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or Items 23a or 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygelen.

Then to Health and Mental Hygelen and the state of 1 ☐ Yes 2 No Montgomery Village Directo Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20313 Highland Hall Drive 20886 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced ۵ Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. State Elementary/Secondary (0-12) College (1-4or 5+) $\tilde{1}\tilde{2}$ Personel Assistant Department 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sara Levis John Cleary 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type, Print) 20313 Highland Hall Dr. Montgomery Village, MD Edward P. Lombard / Husband Baltimore, Oct. 24, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) permit. Pages Department of Important: If it 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville, Maryland 2004 4 □Donation 5 □ Other (Specify) 21. Signalus o Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home Þ 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Poler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) 11188 **Physician** Dheymonia /Medical Due to (or as a consequence of): Examiner ()emen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dub to (or at a consequence of): Examiner requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?

1 Yes 2 No
9 Unknown 5 ☐ Other (specify) 4□Pregnant at time of death P.O. 1 ed by the a detached f 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Yes 3 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 Tyes Division of Vital the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury Natural 5 Pending after death.

I Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by ti determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 0 0 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, Maryland 21701 Casper E. Cline III, M.D. 300 W. 9th Street 32. Registrar's Signature 31. Date filed (Month, Day, Year) State racks OCT 26 2004 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35686 State of Maryland / Department of Health and Mental Hygien ()

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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	19a. Informant's	Name/Relations	ship (Type	, Print)			19b. Mail	ing Address	(Street a	and Numb	er or Rur	al Route Num	ber, City	or Town,	, State, Zip	Code)	
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5												per 1 ☐ Yes	formed? 2 X N		death?	2 No	
0	25. Was case ref	erred to medica	ıl							26. Plac	e of Deat	h (Check only					
0	examiner? 1 Tes 2	No No	Но	spital: 1 🕻	X npatien	t 2 🗆	ER/Outpatie	nt 3 DC	A Othe	ar _		me 5 Re		6 Oth	ner (Specify	1)	
-	27. Manner of De	ath		28a. Date (Mo			28b. Time		8c. Injury Work			28d. Describe				-	
atlon:	1 Anatural 2 Accident	5 Pendii investi		(MO	nun, Day	(adi)	Injury	м		<br Yes 2 □]No						
Tica	3 🔲 Suicide	6 ☐ Could	not be	28e. Plac	e of Injur	y - At ho	me, farm, s	reet, factory	, office			28f. Location	(Street a	nd Numb	per or Rura	I Route Num	ber,
Certific	4 🗌 Homicide	9 4919111		buile	ding, etc.	(Specify	()	,				City or To	own, Stai	re)			
	29a. Certifier	1X Cartiful	na Physic	rian: To 45	a heet of	my kno	wledge dea	th occurred	at the ti-	na data a	nd place	and due to the	a causel	e) and m	annar ac ct	ated	
edical	(Check only one)	2 Medical	Examine	r: On the	basis of e	examina	tion and/or in	vestigation.	in my of	oinion, dea	ath occur	red at the time	, date ar	nd place,	and due to	the cause(s))
меа		ad title of contic	Ar.	and ma	nner stat	ou.		200	License	number			29d D	ate signe	d (Month, I	Day Year)	
_	29b. Signatura a	I III O O CERTIN	1	1	-		An	1					200. 0	Jigi 10	_ (************************************		
		11	1	/)		1	· man	D58	681			ΩC	TORE	P 25	200/	

State Registrar JUDE R. ALEXANDER, M.D., 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850

31. Date filed Month, Day, Year)

OCT 26 2004

Specific Signature

Specific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar	State of Ma	iryland / Depa <i>Ce</i>	artment of F rtificate of			ene a NO O O I.	05603
	(4)		Registrar Decedent's Name (First, Middle, La	st)		timouto or	Doutri	2. Date of Death	2004	G. Nine Count
	Physicia	an	Cynthia Elizab					October	21, 2004	6:11 P M
	/Medic Examin		4a. Fecility Name (If not institution, giv			4b. City, Town, o	r Location of Death		4c. County of Dea	th
			Washington Adven	tist Hospi	tal	Takoma :			Montgome	
	Funeral		Social Security Number 6. S	ox 7. Age □ M 2 tx F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
ш	Director		3/0-/4-1///	- W 2X	50 Yrs.			Jan. 2,	1954 Was	shington, D.C
	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary f sho	ξ	Maryland Prince	George's	Hyattsvi]	1e				1X☐Yes 2☐No
	r 28a	Director	10e. Street and Number	occupe o		10f. Zip Code		10	g. Citizen of What Co	ountry?
	17 with	aiD	5902 31st Avenue	#515		20782		ı	United Sta	ites
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exertical retinal be retified at once.	by Funeral	11. Marital Status 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates:	10	Was Decedent of HIf Yes, specify Cub.	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
20	natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occur kind of work done	oation during most of work d)	ring 1	6b. Kind of Business Parking Di	/Industry
2	ithin ne.	mpie	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retire nistrati		1	Montgomery	
2	lled w tygier ther th	ខ	12 17. Father's Name (First, Middle, Last)	Adılı	Interiact		e (First, Middle, M		
and	d be f	To Be	James Edward Law				Frances	E. Suber	r	
Maryland	Shoul nd Me mark	F	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street			City or Town, State,	Zip Code)
Š	alth a 27 is		Nicole P. Morgan	(daughter	5902	31st Ave	. #515, Н	yattsvil	le, MD 20	0782
Je,	of Hei		20a. Method of Disposition 1 XBurial 2 Cremation 3 D		20b. Place of Disponentery, cre	osition (Name of matory or other pla	св)	Date 2	Oc. Location - City or	Town, State
<u><u>Ĕ</u></u>	Fag timent tant: If		`4 □Donation 5 □ Other (Speci					the state of the s	rentwood,	
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	nspe					eral Servi shington,	
	- 11 3		23a. Part1. Enter the disease, or conshock, or heart failure. List only	polications that caused	the death. Do not en					Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as		COLLA	inst insis			Onset and Death
	pg #is	Examiner	Sequentially list conditions, any least immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):					
	xecut and ul-tran	хап	that initiated events resulting in death) Last		a consequence of):					
9	flicate be executed physician and as the burial-transit	ai		a CARI	DIAC 1/4	LVULIN	DISMASE			
68760,	flicate g phys	edicai		0						
O. Box	death cert	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
<u>a</u>	requires that the een signed by th hould be detache	y P	Part II. Other significant conditions				ven in Part I.			to the cause of death?
rds	w requires that been signed be should be deta	ed t	LEND STAC	is Lin	ME Dis	12456		1 🗆 Ye:	s 2□No 3□P	robably 4 🛣 Unknown
Division of Vital Records,	The law ate has b page 2 sl	Complet	LOWD STA	100Scer	Hermey			24a. Was an autopsy perform	prior to death?	autopsy findings available completion of cause of s 2 1 No
/ita	yslcian: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			han	th (Check only one		
of	Phys this c	- To	1 Yes 2X No 27. Manner of Death	1 LXInpatie	ent 2 ER/Outpatie	HIL JUDON	4 🗀 indising ric	ome 5 Resider 28d. Describe how	nce 6 Other (Spewinjury occurred	əcify)
On	ding F h. After funer	tion	1 Natural 5 Pending 2 Accident investigate	28a. Date of Inju (Month, Da	y Yeer) Injury	Wo	rk?]Yes 2 □ No			
ivisi	al or Attending Physician: after death. I Director: After this certific d in by the funeral director,	ertification:	3 Suicide 6 Could not determine	be 28e. Place of Ini	jury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or F , State)	tural Route Number,
	Hospital or 4 hours afte Funeral Dir tely filled in I	0	29a. Certifier 17 Certifying F	hysician: To the best	of my knowledge, dea	th occurred at the t	ime, date and place.	and due to the ca	use(s) and manner a	as stated.
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one)	hysician: To the best iminer: On the basis o and manner st	f examination and/or i ated.					
	To t To t	Σ	29b. Signature and the of certifier			29c. Licen	50570	29	d. Date signed (Mon	
	3		prace	Cerr N		149	30370	0.1	10/22/	04
			30. Name and address of person who 76/0 C4 31. Date filed (Month, Day, Year) OCT 26 2	completed cause of c	death (Item 23a) (Type 40E Security	Print) I CNA	TAKINA	CAINEE PACE	M.D.	20712
		ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	Anna V.	3/	-		
	Regist	rar	OCT 26 2	JU4 / 100	per fred	Jago colores				

State of Maryland / Department of Health and Mental Hygiere 0.01.

			For State Registrar	State of Maryland	d / Depa <i>Cer</i>	irtment of H <i>tificate of l</i>	ealth and N Death	Mental Hyg R	iene 004	35688
	Physicia	an	Decedent's Name (First, Middle, Last	")				2. Date of Deat Month	Day Year	3. Time of Death
	/Medic		ELLEN KAY LO					OCTOBER	23, 2004	3:30 A M
	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	
			ANNE ARUNDEL MED 5. Social Security Number 6. Se		et hirthday	ANNAPOL If Under 1 Year	LS If Under 24 Hrs.	I P Data of Birth	ANNE ARU	
	Funeral Director			² M ² XF 63	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV 8,	Year) G	rthplace (State or Foreign country) SHINGTON D.C.
			Usual Residence of Decedent	1 03				NOV 0,	1940 WA	DILINGION D.C.
	yland		10a. State 10b. County	10c. City	Town or Lo	cation			-	10d. Inside City Limits
	e Ma	ctor	MARYLAND PRINCE G	EORGE'S BOW	IE					1 ☑ Yes 2 □ No
	라 다 Se De B	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	death with the Maryland ms 23a or 28a-f show r nust be notified at	ral	3510 MADONNA LANE			20715			U.S.A.	
	er de Items	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
003	d within 72 hours after death with the Marylan jene. In than "natural", or liems 23a or 28a-f show tra Madical Examinat mast be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1	1	☐ Yes 2 No	Specify:		Specify: W	HITE
ş	72 hou		15. Decedent's Edu	ucation	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Business	s/Industry
	within 7 ene. than "n	ple	(Specify only highest grad	College (1-4or 5+)	life. L	OO NOT use retired)	ang	MAILING	
7	e filed withln al Hygiene. I other than '	Completed	10		MACE	IINE OPER			INDUSTRY	
_	ild be filed lental Hyg kad other Ic event,	Be	17. Father's Name (First, Middle, Last)	OIII ED			18. Mother's Nam			
<u>X</u>	2 should be and Mental ls marked raumatic ev	10		OWLER			BESSIE	BERNICE	DALTON	
	s 1 and 2 should f Health and Men item 27 Is marka other traumatic	1	19a. Informant's Name/Relationship (T)						, City or Town, State,	Zip Code)
စ	1 and 2 Health tem 27		JEROME EDWARD FOWL 20a. Method of Disposition			MADONNA : sition (Name of natory or other place			20715 20c. Location - City o	r Town, State
<u> </u>	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 N Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Tellioval livili State		natory or other place VETERANS		/2004	CHELTENHAM	. MD
	ortar		21. Signature of Funeral Service Licens						EVANS FUNE	-
ă	Deparenti Deparenti Impo		1 John P.Km	sky					E, MARYLAN	
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	· Chronic	Olos	Wuclie	e Puli	ualale	p Disea	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent				/		
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque	ence of):					
	uted I Insit	Examiner	Cause (Disease or injury							
	executed in and ial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a consequent	ence of):					
8/PU	ificate be executed g physician and as the burial-transit	dicai		d						
Ω :	ntifica ing ph as th	_	IF FEMALE:							
X Q Q	leath certiff attending I for use as	ician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1☐Live birth 2☐Fetal	death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
	law requires that the death certi as been signed by the attending 2 should be detached for use a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of de: 9□Unknown	ath 5⊡	Other (specify)			ivio, iii	54,
7	that the ed by detac	Physi	Part II. Other significant conditions co	ntributing to death but not resul	ting i ∕∩ he ur	derlying cause give	en in Part I.	23e. Did tob	acco use contribute I	o the cause of death?
S	ulres n sign ld be	d by	(auseshue	breat	Van	luce		1 □ Ye	s 2 No 3 P	robably 4 dinknown
ecords,	w req	lete	Anxiela					24a. Was ar	24b. Were a	utopsy findings available
ř.	Physician: The lav this certificate has al director, page 2	Completed						autopsy	y prior to ned? death?	completion of cause of
	ysician: The is certificate hadirector, page	a	25. Was case referred to medical				26. Place of Deat			2 No
-	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🚉 📢 o	Hospital: 1 ☐ Inpatient 2 🔀 E	R/Outpatien	3 □ DOA Othe	Laren .		nce 6 Other (Spe	icify)
ם טו	ng Ph fter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho	w injury occurred	
200	eath. or: A the fu	cati	2 Accident investigation				res 2□No			
DIVISION	or Att	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)		et, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
_	To the Hospital or Attending Pr within 24 hours atter death. To tha Funeral Director: After th completely filled in by the funeral	O	29a. Certifier 1 1 Certifying Phy	sician: To the best of my know	ledge death	occurred at the tim	e date and place	and due to the co	uea(c) and massa-	e stated
:	e Hos 24 ho a Fun etely	edical	(Check on) 2 Medical Exami	iner: On the basis of examination and manner stated.	on and/or inv	estigation, in my op	pinion, death occuri	red at the time, da	ite and place, and du	o to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (Mon	th, Day, Year)
			ADITYA	CUOPRA	UD	157	028		10/23/a.	
			30. Name and address of person who co	ompleted cause of death (Item:	23a) (Type, I	Print)	2. /	10	1112	11.01
			600 Kichgeli	, Auemilie	- 5	ul 23	31 Mu	appolus	MI) 2	1401
	Sta Registr		31. Date filod (Month, Day, Year) 0CT 2 5 2	32. Rigistrar's Signatu	Ire	Land a		V		

29d. Date signed (Month, Day, Year)

2160/

17 October 20011

1 - For State Registra	r
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- State Regis	
1. Decede	ır

Examir

Physici /Medi

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, If a Modical Examinat: Mal be II-III out anone. Baltimore, Maryland 21215-0036

Martha Marvel

Physician /Medical **Examiner** Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To tha Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar				(Jer	tificate of L	Jeam		Reg. No	٠.			
	1. Decedent's Name (First, A	fiddle, Last)				2. Date of De								
ın al	MARTHA B.	MARVE	L		Octobe						17,200)4	011	12 M
er	4a. Facility Name (If not insti	ution, give st	reet and nu	mber)	4b. City, Town, or Location of Death 4c. County of							ath		
ш	Memor	ial E	lospi	tal	Easton Talbot									
	5. Social Security Number 219-01-6939		м 2Хо́ г	7. Age (In ye			If Under 1 Year Months Days	If Under 24 Hr Hours Mir		av. Year)		Jount	ace (State y) LAND	or Foreign
	Usual Residence of Deceder 10a. State 10b. Co			10c.	City, Town	or Lo	cation					10	d. Inside C	City Limits
ō	MD T	ALBOT			EAS.	TON	I							s 2 □ No
rect	10e. Street and Number						10f. Zip Code			10g. Cit	tizen of What (Count	ry?	
Ī	904 S. WASHI	NCTON	CT				2160	1		-	USA		•	
era	11. Marital Status		2. Was Dec	U.S.	13. V	Vas Decedent of Hi	spanic Origin? (Specify Yes or No	0-	14. Race - An		n Indian,		
Completed by Funeral Director	1 ☐ Never Married 2 💢 3 ☐ Widowed 4 ☐ Divo		Armed For 1 Yes If Yes, Gir Year or D	2 XNo		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White							tc. ITE	
ted		edent's Educ			16a. D	eced	ent's Usual Occupa	ation		16b. K	ind of Busines	s/Indi	ıstry	
ple	(Specify only h Elementary/Secondary (0-		College (1-4or 5+)	- "	life. [kind of work done o OO NOT use retired	iuring most of wi	orking					
Son	12		Ŏ.			HC	MEMAKER				OWN HOM	1E_		
Be (17. Father's Name (First, Mic	idle, Last)						18. Mother's Na	ame (First, Middle	, Maiden	Sumame)			
2	WILBERT BU	TLER						HULDA	ANDREWS					
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19c. MARVEL/HUSBAND 904 S. WASHINGTON ST., EASTON, MD 2160													
	LUTHER E. MA	RVEL/H	USBAN		_			NGTON S:		_			-11	
	20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR 10-18-2004 STEVENSVII													íD
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL H											•		
	23a. Part1. Enter the diseas	e, or complic	ations that	caused the de	eath. Do no		O S. HAR or the mode of dying				21601		Approxima	
	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only one	Me	tost			Colon	Corcer	-				Interval Be Onset and Z MS	
	rossining in assum,	-	Due to	(or as a cons	equence of):								
iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	J b.		Due to (or as a consequence of):										
хаш	Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to	(or as a cons	equence of	adirence offi-						-		
n/Medical Examiner		d.												
Mec	IF FEMALE:		15 16									-		
	23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t 23	1 ☐ Live I	tcome of precipinth 2 Fe nant at time o own	etal death	3 <u></u>	Ectopic pregnancy Other (specify)				23d. Date of d Month			Year
Ph)	Part II. Other significant con	nditions cont	ributing to d	eath but not r	esulting in t	he ur	deriving cause give	on in Part I	23e Did	tobacco	use contribute	to the	cause of	death?
Completed by Physicla	H-10	notlyvo nol ("	dism							Yes 2			bly 4 🗆	
mplet	R	nol 10	150/fic	(orc)					24a. Was auto		24b. Were a prior to death?	com	sy findings pletion of a	available cause of
			ension	. 1					1 ☐ Yes	2 No			₽ No	
To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☐ No		ospital:	Inpatient 2	☐ ER/Outp	atien	Othe	200	eath <i>(Check only i</i> Home 5 Aesi		6 □Other (Sp	ecify)		
tlon: 1	27. Manner of Death 1 V Natural 5 Pe	ending vestigation		of Injury oth, Day Year)		ne of	28c. Injury Work	A STATE OF THE PARTY OF THE PAR	28d. Describe			- 7/		
ertifica	3 ☐ Suicide 6 ☐ C	ould not be stermined	28e. Place build	e of Injury - Al ing, etc. (Spe	t home, fam	n, stre	eet, factory, office		28f. Location (City or To			Rural	Route Nun	nber,
dical Certification;	29a. Certifier 1 💟 Certifier (Check only one)	tifying Physi lical Examin	er: On the b	e best of my k asis of exami	nowledge, ination and/	death or inv	occurred at the timestigation, in my op	e, date and place pinion, death occ	e, and due to the curred at the time,	cause(s)	and manner a d place, and du	as sta ue to t	ted. he cause(s)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Pay, Year)

555 Gywood

2. Registrar's Signature

ell a sellen de

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

442587

Easton mo

State of Maryland / Department of Health and Mental Hygier 0 0 L For State Registrar 35690 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Trikley /Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (If not institution, give street and number) Examiner Stella Maris Hospice @ Mercy Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth July21, 1952 6. Sex 9. Birthplace (State or Foreign Maryland **Funeral** 1 □ M 2 🛛 F Days Hours 577-70-3729 52 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other treumatic event, the Medical Examiner must be notified at Beltsville Prince George's 1 ☐ Yes 2 No Maryland Director 10f. Zip Code 20705 10g. Citizen of What Country? United States 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "naturel", or Iteme 23a or 3 any injury or gither treumatic event, the Medical Examiner must hem. 4600 West Caroline Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self employed Restaurant 18. Mother's Name (First, Middle, Maiden Sumame)

Betty Wood 17. Father's Name (First, Middle, Last) Dolan Charles 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State Zip Code) 4600 West Caroline Avenue Beltsville, Maryland 20705 19a. Informant's Name/Relationship (Type, Print) Robert A. Milne -son 20b. Place of Disposition (Name of commetery, crematory or other place)

Metropolitan Crematory 10/30/2004 Alexandria, Virginia 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WNG CANCEL Physician FTA8MIC disease or condition resulting in death) /Medical-Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Nother (Specify) How Spice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LEDATUS MO DUDBER 24, 2004 1247 934 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORR, M 2120L RUEPANIS MO 301 ST. PAUL PLAUR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 26 2004 Registrar

Mental Hygiene

	For	State of Maryland / Department of Health and I
_	State Registrar	Certificate of Death

Physici /Medic Examin	a
Funeral Director	

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23s or 28s-1 show ir than "natural", or Itama 23a or 28a-f show The Medical Examinat must be notified at 10.

Baltimore, Maryland 21215-0036 or other traumatic event, Pages 1 and 2 should be fill ment of Health and Mental H sant: If itsm 27 Is marked of permit, Page Department of Important: If any injury or once. **Physician** /Medical **Examiner** The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, the attending physician signed by peeu has certificate or Attanding Physician: director, completely filled in by the funeral After Director: To the Hospital o within 24 hours af To the Funaral D 3

1. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 25, 2004 8:46 AM BURNELL ADDISON MIKESELL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL TANEYTOWN ANGELIC ARMS ASSISTED LIVING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. OCTOBER 12,1924 Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **X**XM 2□ F Months Days Hours Min. 80 219-14-7985 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 No Director HANOVER PENNSYLVANIA YORK 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 17331 20 MOUL AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 X Married 1 ☐ Yes XX No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) PRINTING COMPANY JANITOR / PAINTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ESTA ISABELLA KINDIG ADDISON FRANKLIN MIKESELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 MOUL AVENUE, HANOVER, PA 17331 BETTY J. MIKESELL/WIFE 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation XX Removal from State
 4 □ Donation 5 □ Other (Specify) 10/30/04 HANOVER, PA REST HAVEN CEMETERY 21. Signature of Funeral Service Licenses 22 MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESMITINSTER, MD 21157 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final URUSEASIS 2 week resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Nother (Specify 53 57 CA Hospital: 1□Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of sertifier 10/26 12004 D31660 Golew in imas he 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 291 STONER AVENUE STE 203, THOMAS K. GALVIN M.D. WESTMINSTER, MD

DHMH 17 Rev 1/2001

State

Registrar

31 Date filed (Month, Day, Year)

32. Registrar's Signature

OCT 2 6 2004 Blown & Sparle

State of Maryland / Department of Health and Mental Hygieren () 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month RITA LESSNER OCTOBER 20, 2004 10:45 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BEDFORD COURTS ASSISTED LIVING SILVER SPRING MONTGOMERY 7. Age (In yrs. last birthday)

Q?

Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCT • 9 • 19 1 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕏 F Director 224-46-1391 MARYLAND Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Deportment of Health and Mental Hygiene.
Importent: If Item 27 is marked other then "netural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 □ No Completed by Funeral Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3330 N. LEISURE WORLD BLVD., # 229 20906 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 YEARS HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DAVID H. LESSNER LILYE LEHMAN ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3330 N. LEISURE WORLD BLVD., # 229, SILVER SPRING LILLIAN M. PERPER DAUGHTER 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 ★ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State KING DAVID MEM. GARDENS 10/22/2004 FALLS CHURCH, VA. ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Sonald (Cottlement 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBROVASCULAR DISEASE disease or condition resulting in death) 2 YEARS /Medical Due to (or as a consequence of): Examiner HYPERTENSION 204 YEARS E-quantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examine or Attending Physicien: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Hospital: Other 4 Nursing Home 5 Residence 6 XOther (ASSISTED LIVING 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D30844 OCTOBER 20, 2004 30. Name at address of person who completed cause of death (23a) ype, Print) F. McMURRY, M.D., JAMES 4701 ARANDOLPH ROAD, ROCKVILLE, MD 31 Date filed (Month, Day, Year) 32. Registrar's Signature State 26 2004 Registrar

			For State Registrar	State of Maryla	nd / Depa	artment of H rtificate of L	lealth and Death		gien <mark>2e () (</mark>)	4	356	93
	le contrato		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of	Death
	hysicia /Medic		John Willard Nall						23, 20	004	3:20	а м
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s 1 a	Item r othe		20a. Method of Disposition	1	. Place of Dispo cemetery, cre	osition (Name of matory or other place	e) Oct	Date ober 28,	20c. Location -	City or To	wn, State	
Page nent o			1 ⊠Burial 2 □ Cremation 3 □Re '4 □ Donation 5 □ Other (Specify)	emoval from State		of Heaver metery	1		Silver S	Sprin	g, Mar	yland
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LIVISION Ital or Attending rs after death.	al Director led in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	treet, factory, office		28f. Location (S City or Tow		er or Rura	Route Num	ber,
he Hospl in 24 hour	To the Funeral D completely filled in	edical	(Check only 2 Medical Examir one)	sician: To the best of my ler: On the basis of exame and manner stated.		nvestigation, in my o	pinion, death occ	curred at the time, o	date and place,	and due to	the cause(s	5)
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	ent	V		~			L0123350	8	المراحة	1.04		
			30. Name and address of person who co Matthew W. Newman	n, M.D. Nat	ional N	, Print) Naval Medi	cal Cen	ter, 8901	Wisconsir	a Ave,	Bethese 20	da, MD 889
	Sta Regista		31. Date filed (Month, Day, Year) OCT 2 6 2004	32. Registrar's Si		Sparks	/					

			1 - For State Registrar	State of Ma	aryland	Depa Ce	artment of F <i>rtificate of</i>	lealth ar <i>Death</i>	nd Menta		en @ () () [g. No.	35694
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Z	and 2 ealth m 27 i		LILLIAN NAIMAN,	WIFE								R SPRING, MD
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cords	requires een sign hould be	ed by								1 🗌 Yes	2 □ No 3 □	Probably 4 Nunknown
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r	0 5 0	Com							10	perform	ed? death	? Yes 2□ No
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	ding F h. After funer	tlon	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury	Wor	ryat rk? Yes 2. □No		escribe hov	v injury occurred	
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	ne Hospitel or Al 124 hours efter of 10 Funerei Direct 19tely filled in by	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best of miner: On the basis of and manner sta	examinati	vledge, deat on and/or in	h occurred at the til vestigation, in my o	me, date and p ppinion, death	place, and due occurred at th	e to the cau	use(s) and manner e and place, and c	as stated. lue to the cause(s)
	To the h within 2. To the f complete	Me	29b. Signature and title of certifier) -	4		29c. Licens	e number		29	d. Date signed (Mo	onth, Day, Year)
	10		I Custre	Newa	le 1	W	D00	56153		ОС	TOBER 20	, 2004
	1~		30. Name and address of person who KRISTIE NOWAK, M					SILVER	SPRING	, MD	20910	
٠.	Sta Registr		31. Date filed (Month, Day, Year) OCT 26 2	32. Registra	-		Spark					

State of Maryland / Department of Health and Mental Hygien 35695 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HENRY HARRISON PURDY 1125 12 2004 October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1 Hospita Talbot Memoria1 Easton
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) JAN 17 1917 **Funeral** Sex X M 2 □ F Birthplace (State or Foreign Country) Months Days Hours 716-03-6317 87 Director PA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits iral', or Items 23a or 28a-f show Examiner must be notified at XXYes 2□No Director MD TALBOT EASTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 500 HAZELWOOD DRIVE 21601 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify WHITE 3 Widowed 4 Divorced "natural" traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BUSINESS College (1-4or 5+) marked other than Elementary/Secondary (0-12) Hygiene. 12 ACCOUNTANT ACCOUNTING Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked oth any injury or other traumatic event any injury or other traumatic event ans. Be HENRY H. PURDY NEVA PARLETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNA G. PURDY/WIFE 500 HAZELWOOD DRIVE, EASTON, MD 21601 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) SPRING HILL CEMETERY 10-16-2004 EASTON, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 OHN 17. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** e. wan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2: No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2/No 1 __npatient Certification: To 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerat Dire 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 856 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BYSSHE, JR M.D. 505 DUTCHMANS LANE EASTON, MD 21601 STANLEY M. 31. Date filed (Manth, Day, Year) . Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2 1 1 4

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			Registrar 1. Decedent's Name (First, Middle, La.	st)			imour	.0 0, 2	Journ	2. Date of Dea			3. Time of Death
	Physicia	an								Month	Day		n M
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	Examin	eı	Collingswood Nur				D	ockvi	110			Montgon	10777
	Funeral		5. Social Security Number 6. S		e (In yrs. las	t birthday)	If Unde	r 1 Year	If Under 24 I	Hrs. 8. Date of Birth	h	Montgon 9. Bir	thplace (State or Foreign
Е.	Director		212-03-1192	X M 2□ F	8	7 Yrs.	Months	Days	Hours N	Jan. 24	, 19	17 It	aly
	P .		Usual Residence of Decedent		140.00								10d Inside City Live
	arylar	<u>_</u>	10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🖾 No
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	with ti		10e. Street and Number				10f. Zi	p Code			rog. Citiz	zen of What Co	ountry ?
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336	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 ℃ No	Specify:			Specify: Wh	ilte
ŏ	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "naturel", or items 23e or 28e-f show event, its Medical Examiner must be notified at	ted	15. Decedent's E	ducation		16a. Deced	dent's Usu	ial Occupa	ition uring most of	working	16b. Kir	nd of Business	Andustry
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yla	Meni Meni arke	၉	Ferdinando Parl							eresa Cont			
Maryland 21215-0036	2 sh and is m	1 8	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	ng Addres	s (Street a	nd Number o	r Rural Route Numbe	r, City or	Town, State, .	Zip Code)
	ages 1 and 2 should be fi nt of Health and Mental H t: If Item 27 is marked ot y or other traumatic ever		Ferdinando J. Pa 20a. Method of Disposition	rlato/ Sor		791 of Dispo			kride	Drive, I		letown, cation - City or	MD 21769
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Baltimore,	permit. Page Department Important: If eny injury or once.		21. Signature of Funeral Service Lice	000		2f	ranc	inive	. Coll:	ins Funera	l Ho	me Inc	ng, Md 20901
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,			shock, or heart failure. List only Immediate Cause (Final	one clause on each I	ine.		1						Interval Between Onset and Death
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Вох	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetal de	eath 3		oregnancy			2	3d. Date of de Month	livery Day Year
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		11	3, Ny e and address of person wh	completed cause of	death (Item 2	3a) (T pe.	Print)	b.Z	. 10	he b	Z	va Ini	23 ₎ 2004 D 2025 201
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State of Maryland / Department of Health and Mental Hygiepen 0 [35697 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCT. 15 2004 DOROTHY QUATHAMER 1:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT EASTON WILLIAM HILL MANOR 8. Date of Birth (Month, Day, Year) AUG.16,1928 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Hours Min. Months Days MARYLAND 76 Director 213-24-2025 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State itam 27 la marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Marital Examiner must be natified at 1 ☐ Yes 2X No Director CAROLINE DENTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8965 DOUBLE HILLS ROAD 21629 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filled within 72 h and Mental Hygiene. 7 Is marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) -0-BOOKKEEPER PRINTING 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ELIZABETH LeCOMPTE JAMES EARL STEVENS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an itam 27 la LORRAINE SECRIST/ DAUGHTER 28629 FORREST LANDING ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ■ Removal from State Date 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If iter
eny injury or oth VETERAN CEMETERY 10-19-2004 HURLOCK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 MERCERS MADE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 16 Physician Weeks /Medical Due to (or as a consequence Examiner neo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (on as a consequence of) Examine eval death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buria P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 ☐ Yes 2 Hospital or Attanding Physician: 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending within 24 hours after death.

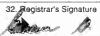
To the Funaral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier elleam Na 30. Name and address of person who completed cause of death (I - 3a) (Type, Print)

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)

OCT 15 2004





WILLIAM H. WOOD, JR., M.D., 501 DUTCHMAN'S LANE, EASTON, MD 21601

State of Maryland / Department of Health and Mental Hygien 2 🛭 🕽 🗓 👢 35698 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Rochester 05 October 13,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chester Kiver Center hes tertown Hospita If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) en 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex **Funeral X**M 2□ F Days 56 Director 216-54-7652 MD Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-1 show It s Medical Examinar must be notified at 1 X Yes 2 No Director MD Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Hadaway Dr. Apt 6A 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If Item 27 Is marked other th jury or other traumatic event, ILs Dance Brothers 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Asbury Rochester Lorraine Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Rochester(wife) 200 Hadaway Dr. Apt 6A Chestertown, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩Burial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If sny injury or once. Rochester Cemetery 10-20-04 4 ☐ Donation 5 ☐ Other (Specify) Ingleside, Maryland 21. Signature of Puneral Service Licen 22. Name and Address of Facility Frince Bennie Smith FH-Worton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myanta disease or condition resulting in death) /Medical Due to (or as a conseque INF CARDIOMY OPATINE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed tran resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ hknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate 1 Yes 2□ No 1 Tyes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 2 No ၉ 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 6 ☐ Other (Specify) 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural Injury after death.
I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannerstated. (Check only one) 29b. Signature title of certifie 29d. Date signed (Month, Day, Year) 10060301 ruse of death (Item 23a) (Type Print)

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SPENN , STES, CHOSTERTOWN, MD 21640 reinen. 20 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiere

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December Stamp First Models Latery Catherine To Virginia Rhyanos S. Copy, Johnson Control of First Models Latery S. Copy Stamp Fir									Certific	cate of	Death)		Reg. N	lo.			-
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			1 - For State of Maryland / Dep	partment of Health and Mertificate of Death	Mental Hygie Rag.	ne2004 35700
	Physici /Medic		1. Decedent's Name (First, Middle, Last) James Wayne Roy		2. Date of Death	29, 2004 4:50p. M
}	Examir		4a. Facility Name (If not institution, give street and number) 112 Chambers Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Federalsburg () If Under 1 Year If Under 24 Hrs.		4c. County of Death Caroline
	Funeral Director		217-50-3201 1XM 2□ F 55 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 31	9. Birthplace (State or Foreign Country) 9. Baryland 1.1949 Maryland
	h the Marylar or 28e-f show a rodified at	Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Location Lsburg 10f. Zip Code	10g.	10d. Inside City Limits 1 ☐ Yes 2 ☐ No Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Eventher must be notified at ODGE.	by Funerai D	112 Chambers Street 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 11. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Λ Year or Dates:	21632 . Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:		ited States 14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	ed within 72 hou /giene ier than "nature t, the Medical E	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mac	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) hinist	king	. Kind of Business/Industry
yland	ould be file Mental Hy larked oth	To Be	17. Father's Name (First, Middle, Last) James Roy	Kathle	en Recka	rt
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Itimor	it. Pages intment of h intant: If its njury or o'		'4 © Donation 5 □ Other (Specify) Anatomy	ematory or other place) Gifts Reg. 10/	30/04 Ha	nover, Maryland
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Division of	or Attendentifier deat	Certificati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dear one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier and I m D	29c. License number D35284 Print) Dashungton St	29d. [Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type ANDREA ALLEN MA 21.9 S CA	lashington St	eastm	mD 21601
	Sta Registr		31. Date filed (Month, Day, Year) NOV 3 200 - 32. Registrar's Signature	park		

State of Maryland / Department of Health and Mental Hygie 35701 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Raymond L. Rogers /Medical 20. 2004 Oct. 5:58 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8396 Pipping Rock Court Millersville Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Feb. 10, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 216-28-6732 72 Yrs. MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County ?7 is marked other than "natural", or itams 23a or 28a-f show traumatic avent, the Modical Examinar must be notified at 10d. Inside City Limits MD Anne Arundel Millersville Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? with 8396 Pipping Rock Court 21108 USA Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married 1 X Yes 2 ☐ No Baltimore, Maryland 21215-0036 Spacify: White 1 ☐ Yes 2 ☑ No δ Specify: 3 ☐ Widowed 4 ☐ Divorced Korea Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "rany injury or other traumatic avent. In a Mental Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Customer Relations BG&E 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Rogers Thelma Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela E. Rogers/Wife 8396 Pipping Rock Court, Millersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct. 23 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD DANTIR 21146 23a. P. rt1. Iter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hoc or heart failure. List only one cause on each line. Approximate Interval Between Set and Death Im e ate Cause (Final disease or condition resulting in death) Pnysician 6mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated average) Dualto (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai use as the attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No 2 No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: ٥ 1 ☐ Yes 2 📉 No ÷ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Injury at Work? After Natural 5 Pending death, investigation 1 ☐ Yes 2 ☐ No 2 Accident atter death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and life of certifier 29d. Date signed (Month, Day, Year) reber 2 who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year, State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 10 Virginia Lee Shortall 15 2004 10;35p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Genesis Eldercare, The Pines Talbot Easton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 71 217-30-8318 Director 9-4-1933 Harwood, MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Madical Examiner must be notified at Talbot MD St. Michaels 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25212 St. Michaels Rd. 21663 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or lier any injury or other traumatic event, the Moutest Examination 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 10 years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Luther Dove Lillian Louise Tucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 19a. Informant's Name/Relationship (Type, Print) 9212 Hummingbird Ter., Gaithersburg, MD. Ruth Ann Shortall (daughter) 20b. Place of Disposition (Name of cametery, crematory or other place)

Capitol Crematory 10-17-2004 Dover, DE. 20c. Location - City or Town, State 20a. Method of Disposition * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
R. Carroll Hurley Funeral Home, PC P.O. Box 518, St. Michaels, MD. 21663 for enter the mode of dying, such as cardiac or respiratory arrest. Carer Approximate Interval Between Onserand Death 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner r as a consequence To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4□Pregnant at time of death 5 Cther (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 23e. Did tobacco use contribute to the cause of death? ð 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy регогл 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

30. Name and

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mpleted cause of death (Item 23a) (Type, Print)

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aminer				er)			wn, or Locatio	n of Death			County of Death	
eral	14800 Keenel 5. Social Security Number	and (Age (In yrs. I	ast birthday		otomac Year If Und	er 24 Hrs.	8. Date of Birt	h	ont gome	
ctor	571-33-8939	1	□M 2⊠F	90	Yrs.	Months I	Days Hour	s Min.	(Month, Da Feb. 1	y, Year) , 191	14 Ha	place (State or Fore intry) iti
523	Usual Residence of Deceden 10a. State 10b. Cor			10c City	, Town or L	ocation						10d. Inside City Lim
event, the Medical Examinating matter addition at Be Completed by Funeral Director	_	-										1 ☐ Yes 2 🖾 I
be natifie Directo	Maryland Mor	tgom	ery	IN •	Poto	10f. Zip C	nde			10a Citiz	en of What Cou	intry?
		and (rirole			10112190	2087	Ω			ited Sta	
Funeral	11. Marital Status	aria (12. Was Decede		S. 13.	Was Deceder			cify Yes or No Rican, etc.)		4. Race - Amer	ican Indian,
		Married	Armed Force 1 ☐ Yes 2 £ If Yes, Give			1 Yes, specify			Hican, etc.)	-	Black, White	, etc.
d by	3 ☑ Widowed 4 ☐ Divor	ced	Year or Date	s:		10 105 24	No Spec				Specify: Wh	ite
r, the wedical to	15. Dece (Specify only hi	dent's Ed thest gra			16a. Dece	dent's Usual (kind of work DO NOT use	Occupation done during m	ost of workir	ng	16b. Kin	d of Business/I	ndustry
imail ami	Elementary/Secondary (0-1	2)	College (1-4c	r 5+)		anist	retirea)			М	ıi o	
ပိ	17. Father's Name (First, Mid	tle, Last)			<u> </u>	anist	18. Mo	ther's Name	(First, Middle,	Mus Maiden		
To B	3	1					C	laire	Gaetje	าร	,	
į -	19a. Informant's Name/Relat		ype, Print)		19b. Maili	ing Address (S					Town, State, Zi	p Code)
	Mary Elizabet	n Scł	neider		14800	Keene	land C	ircle,	North	Poto	omac, MI	20878
Ē	20a. Method of Disposition 1 Burial 2 □ Cremati	. 2 🗆	Domoval from Cta		ace of Disponentery, cre	osition (Name matory or othe	of or place)	D	ate	20c. Loc	ation - City or T	own, State
B	`4 □Donation 5 □Othe				L Soul	s Ceme	tery	10/26	/2004	Gern	nantown,	Maryland
any injury or other traumatic even	21. Signature of Funeral Sen	ice Licen	See A		1	2. Name and . O East	Address of Fac	cility DeV	ol Fune	eral	Home	
. O	23a. Part1. Enter the disease	LA	10-1			0 East aither						
	shock, or heart failure.	ist only	one cakes on each	iline.			ir dying, such	as cardiac o	r respiratory ar	rest,	ĺ	Approximate Interval Between Onset and Death
an al	disease or condition resulting in death)	-	a. Alzheim			ia						Years
er			Due to (or a	as a consequ	ience or):							
je 📕	Sequentially list conditions,		b. — Due to (or :	as a consequ	ence of							
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	c									
EX			Due to (or a	as a consequ	ence of):							
cian/Medical Examin			d.									
Mec	IF FEMALE:											
by Physician	23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcon 1□Live birth 4□Pregnant	2 Fetal	death 3	Ectopic preg				2.	3d. Date of deliv Month	e ry Day Year
hysician/Medi	1 □ Yes 2 🛣 No 9 □ Unknown		9□ Unknown		iatii 5	Other (spec	(y)	-				
0	Part II Other significant con	litions co	ontributing to death	but not resu	lting in the u	inderlying cau	se given in Pai	11.	23e. Did to	bacco us	e contribute to t	he cause of death?
d by									1 □ Y	es 2🛭	No 3 □ Pro	pably 4 Unknow
ompieted									24a. Was	an i	24b. Were auto	ppsy findings availab
J W									autop perfor	med?	prior to co death?	impletion of cause of
O	25. Was case referred to med	ical					26. Pla	ce of Death	1 ☐ Yes (Check only or	2 No	1 🗆 Yes	2 No
To B	1 Tyes 2KN No		Hospital: 1 ☐ Inpa	tient 2 🗆 E	ER/Outpatier	nt 3 DOA	Othon				☐Other (Special	fy)
		ding	28a. Date of Ir (Month, L	jury Day Year)	28b. Time o	f 28c	Injury at Work?	2	8d. Describe h	ow injury	occurred	
satio	2 Accident inv	stigation				М	1 ☐ Yes 2	□No				
ertification;	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide del	ıld not be ermined	286. Place of I	njury - At ho etc. <i>(Specify</i>	me, farm, str	reet, factory, c	ffice	2	8f. Location (S City or Tow	treet and n, State)	Number or Run	al Route Number,
S)	L.: P1	1		Landara De Ca							
	29a. Certifier 1 X Cert	ying Phy	sician: To the be	st of my know	viedge, deat	n occurred at	ne time, date	and place, a	nd due to the d	ause(s) a	ind manner as s	tated.
lical	(Check only 2 Medi	ai Exam	iner: On the basis	of examinati	ion and/or in	vestigation, in	my opinion, d	eath occurre	id at the time, t	iate and p	place, and due t	o the cause(s)
Medical Certi	(Check only 2 ☐ Medi one)		and manner	of examinati	on and/or in		my opinion, d				signed (Month,	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

MD

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October 25, 2004

rype of Finitin black indelible link. Ensure All Copies Are Legible	
State of Maryland / Department of Health and Mental Hygien 0 4	35701
Certificate of Death Reg, No.	00,0

			1 - State Registrar		Ce	rtificate of	Death		Re	€ U U eg. No.	7	00,0.
			1. Decedent's Name (First, Middle, La	ist)				2.	Date of Deat	h		3. Time of Death
	Physici /Medio		THEA A. SONNENMA	RK				00		21, 20	Year 104	1:44 PM M
	Examir		4a. Facility Name (If not institution, gire			4b. City, Town, o	or Location of	Death		4c. County	of Death	
			WASHINGTON ADVEN				AKOMA			<u> </u>		TGOMERY
ŀ	Funeral Director		,	Sex 7. Ag 1 □ M 2 4□ F	e (In yrs. last birthday	Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, 13/192	Year)	COL	nplace (State or Foreign untry) TRIA
	/land		10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	Man B-f sh	tor	MARYLAND MONTGO	4ERY		SILVE	ER SPRI	ING				1 Yes 2□No
	or 28	Olrec	10e. Street and Number			10f. Zip Code			10	0g. Citizen of	What Co.	intry?
	23a	la	3210 NORTH LEISU	REWORLD BL'	VD APT518	2	20906				U.	S.A.
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event. It e Medical Examiner must be indiffered.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🎇 No	an, Mexican,	in? (Specify Puerto Ric	Yes or No- an, etc.)	Blad	ce - Americk, White	
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gr		16a. Deci	edent's Usual Occup kind of work done	pation	of working		16b. Kind of B	usiness/lr	ndustry
2	within ene. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retire	d)	or working				
	filed w Hygiei ther ti		17. Father's Name (First, Middle, Lasi	4		TEACHER	19 Mother	to Namo /F		PUBLIC Maiden Suman		CATION
and	d be f ental l	To Be	HERMAN NEURINGER	,					ZUNDE		10)	
Maryland	2 should and Men is marke	F	19a. Informant's Name/Relationship			ing Address (Street	and Number	or Rural R	oute Number,	City or Town,		p Code)
di.	1 and 2 Health am 27 i		EDIE BLITZSTEIN/I	DAUGHTER		9 CHEROKE	E LANE	-				832
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or oil		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Con		1	osition (Name of ematory or other place EMORIAL G		Date 0 / 24 / 2		OLNEY,		
Balt	permit. Departr Importa any inju		21. Signature Fune of St. uice Lin	1500	E	2. Name and Addre	ss of Facility EL FUN	ERAL	DIRECT	ION, I	NC.	20050
			23a. Part1. Enter the disease or con shock, or heart failure. List only	iplications that caused		091 ROCKV Iter the mode of dying					ARYL	Approximate
	Physician		Immediate Cause (Final	one cause on each iii	94,000	1000	To	. A	-			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Dua to (or as	a construence of):	naiai	ya	uur	e			
	Examiner		Sequentially list conditions	b. Sout	co of	ecrosis	all	d t	night	al xx	ene	247
	70 ±	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence or):							
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of);							
68760,	certificate be executed ding physician and se as the burial-transit				a consequence or,							
687	ficate p phys	/Medical		_ d								
P.O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	!			23d. Dat	te of deliventh	ery Day Year
S,	s that ned b s deta	by Pł	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	ınderlying cause gıv	en in Part I.		23e. Did toba	acco use cont	ribute to t	the cause of death?
rds	w require been sig should b								1 🗆 Yes	s 2□No	3 Prot	bably 4 Unknown
Record	2 2 2	Completed							24a. Was an autopsy perform	ed?	Were auto prior to co death?	opsy findings available ompletion of cause of
ita	ysician: The is certificate hidirector, page	Be (25. Was case referred to medical examiner?				26. Place o		neck only one			
<u></u>	Physic this c	P	1 ☐ Yes 2 No	Hospital:			4 🗀 14013			nce 6 Othe		fy)
Division of Vital	ding I	atlon:	27. Manner of Death ↓ Natural 5 □ Pending 2 □ Accident investigation		ry 28b. Time of Injury	Wor	yat k? Yes 2∐No		Describe how	w injury occurr	ed	
Dİ	i He	Certification:	3 Suicide 6 Could not be 4 Homicide		ury - At home, farm, st c. (Specify)	reet, factory, office			Location (Stre City or Town,		er or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (29a. Certifier Check only one) Certifying Pl	nysician: To the best on the basis of and manner sta	examination and/or ir	h occurred at the tin evestigation, in my o	ne, date and p pinion, death	place, and occurred a	due to the cau t the time, dat	use(s) and ma te and place, a	nner as s and due to	tated. o the cause(s)
	To th within To th comp	M	29b. Signature and title of certifier	0(1)		29c. Licens	e number		29	d. Date signed	i (Month,	Day, Year)
)	5		→ 96	toldhar -		28	883.	d		10/22/2	2004	
			30. Name and address of person who	complete to use M	eath (Item 23a) (Type,							
					LL AVENUE	#440, TAK	OMA PA	RK, M	ARYLAN	D 2091	12	
	Sta Registr	_	31. Date filed (Month, Day, Year) OCT 2 6 20		ar's Signature	Sparks	P					

State of Maryland / Department of Health and Mental Hygien [] [] L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Yeer **Physician** 630 A M ALICE REGINA THOMAS OCTOBER 1.3 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MALLARD BAY NURSING HOME CAMBRIDGE DORCHESTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year, Jan, 5, 1917 Birthplece (State or Foreign Country)
 Maryland 7. Age (In vrs. last birthday) **Funeral** 1□M 2XF Director 199-03-9414 87 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland | Dorchester Hurlock 10e. Street and Number 10f, Zip Code 10g. Citizen of Whal Country? or items 23a 4728 Skeet Club Road Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: þ Specify: 3 Nidowed 4 Divorced "natural", **Black** Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any njury or other fraumatic event, the MORGS. College (1-4or 5+) Quailty Control Acme Markets 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milbourne ျှ Strawberry Dolly Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne McGlotten / Son 1517 Nedro, Philadephia, Pa. 19141 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Petersburg Cemetery 10-19-2004 Hurlock, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee 516 S. Main Street, Hurlock, Maryland 21643 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cirr hosis Physician 4024 resulting in death) /Medical Due to (or as a consequence of): Examiner heart failure congestive Squenially ist condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the description Due to (or a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of). the attending physician P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐ Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by mellins 3 Probably 4 Onknown 2 🗆 No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 2 No 1 Yes 25. Was case referred to medical examiner?
1 \(\text{Yes} \) 2 \(\text{U46} \) Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funerel Director: After th
completely filled in by the tuneral 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0059973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54 Cambridge MD 216/3 100 Brambu lohnson 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

8

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Mai	ryland /	Depa Cer	tificate of E	ealth an Death	2. Date of	Reg.		4	35706 3. Time of Death
	Physici		SEYMOUR	TUROK					Month OCTOB		Day Ye	ar	8:15 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give s				4b. City, Town, or	Location of [EK Z	4c. County of 0		0.15 A
			1801 E. JEFFERSON	STREET, #	421		ROCKVILI	LE			MONTGO		
	Funeral Director			M 2□F	(In yrs. last i	Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of (Month, MAY	Birth Day , $Y \in {1}$	9. 916	Birthpla Country NEW	ce (State or Foreign y) JERSEY
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation					100	d. Inside City Limits
	a-f sh	tor	MARYLAND MONTGOMER	RY	ROCK	VILLE	E						1 ∏Yes 2 ☐ No
	or 284	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of Wha	t Countr	y?
	ath w	rail	1801 E. JEFFERSON S			12.1	20852		0.10		JNITED S		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show among highly or other traumatic event, the Modical Examinating multiped at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 			Vas Decedent of His Yes, specify Cuban ☐ Yes 2🌠 No	Specify:	1? (Specify Yes or Puerto Rican, etc.)	NO-	14. Race - / Black, V	WHI	c.
2-0	72 hou	ted	15. Decedent's Educ (Specify only highest grade		16	Sa. Deced	ent's Usual Occupa kind of work done di	tion	f working	161	b. Kind of Busin		
21215-0036	d within 7 giene. er then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+ 5+)	DENT	OO NOT use retired)	, , , , , , , , , , , , , , , , , , ,	Working		DENT	ISTI	RY
Maryland	be filed stal Hygi ed other event, I	Be (17. Father's Name (First, Middle, Last) NATHAN	TIDOV					Name (First, Mid		20		
7	hould of Men marke	ဥ	19a. Informant's Name/Relationship (Type	CUROK De. Print)	1	9b. Mailin	g Address (Street a		LICE or Rural Route Nu		ECHT	te. Zip C	ode)
	nd 2 saith ar 27 is r trau		JANET TUROK, WIFE	, ,			. JEFFERS						
ore,	of Hee		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 XR	emoval from State	20b. Place	of Dispos	sition (Name of natory or other place		Date		c. Location - City		
Baltimore,	trant of tant: If it iluy or o		*4 □ Donation 5 □ Other (Specify))	NATIO		CREMATORY	10	/27/2004	FA	LLS CHU	RCH,	VA
Bal	permit. Departr Imports any Inji		21. Sign (ure if Fur rat Service License	free			Name and Address WARD SAGE 191 ROCKV	LLLE P	IKE, ROC	KATT	LE, MD	208	352
			23a. Part1. Enter the disease, or complic shock, or heart aithre. List only on Immediate Cause (Final	e cause on each line		1	4	, such as ca	rdiac or respirator	y arrest,		11	opproximate interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a	SON S		sease					5	
ı	Examiner		Sequentially list conditions	,									
	be sit	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequenc	e of):							
	execute and al-tran	Examine	that initiated events cresulting in death) Last	Due to (or as a	consequenc	e of):							
68760,	icate be executed physicien and s the burial-transit	edicai E											
	entifica ling ph e as th	Med	IF FEMALE:	2. 16									
P.O. Box	the death certif / the attending ched for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1⊡Live birth 2 4⊡Pregnant at ti 9⊡ Unknown	Fetal dea		Ectopic pregnancy Other (specify)			-	23d. Date of Month		ay Year
	law requires that the de as been signed by the 2 2 should be detached t	þ	Part II. Other significant conditions con	tributing to death but	not resulting	g in the un	nderlying cause give	n in Part I.		id tobac □ Yes	co use contribut	te to the	_
Vital Records,	0 4 9	ompieted				-				utopsy erformed	prior deat	to comp	y findings available pletion of cause of
ital	sician: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?						Death (Check on				<u> </u>
5	Phys this al dia	၉	1 Yes 2 No H	ospital: 1 Inpatient 28a. Date of Injury		Outpatient		4 Nursi	-		e 6 Other (Specify)	
O	Attending I r death. ector: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	28c. Injury Work' M 1 □ Y	at es 2 □ No		JOHOWI	injury occurred		
Division	i Si te	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.		farm, stre	eet, factory, office			n (Stree Town, S	nt and Number o	r Rural F	Route Number,
	Hospital	Medical C	(Check only 2 Madical Examin	sician: To the best of her: On the basis of e	examination								
	To the within 2. To the complet	Med	one) 29b. Signature and title of certifier	and manner state	9d.	1. 0	29c. License	number		29d.	Date signed (M	fonth, Da	ly, Year)
	10		Patricia Tom	steo 1	nay,	MA	Do	5191.	6	0	ct. 25	, 20	004
	L		30 Name and address of person who co Patricia Tomsko /	mpleted cause of dea	Rock	a) (Type, I	le Pike,	6-100	? Rock	vill	le, mD	20	852
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 6 2004	32. Registrar	's Signature	G	Sparker	,			,		

			For State Of M State Registrar 1. Decedent's Name (First, Middle, Last)	aryland / Depa Cer	tificate of Dea		Rag. No.
ı	Physici /Medi		KATHERINE C. TORELL			2. Date of D Month Octobe	Day Year
	Examir		4a. Facility Name (If not institution, give street and number) 15609 Jones Lane		4b. City, Town, or Loca Darnestown		4c. County of Death Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If U	nder 24 Hrs. 8. Date of Bi urs Min. (Month, D	irth 9 Birthplace (State or Foreign
	Director		142-38-7899	59 Yrs.		Jan.	l, 1945 New York
	show	ž	10a. State 10b. County	10c. City, Town or Loc			10d. Inside City Limits 1 ☐ Yes 2 X No
	r 28e-f	Director	Md. Montgomery 10e. Street and Number	Darnestov	VN 10f. Zip Code		10g. Citizen of What Country?
	ath with	ralD	15609 Jones Lane	-	20878		United States
036	urs after de al', or items Examinar m	by Funeral	11. Marital Status 1 □ Nøver Married 2 ☒ Married 3 □ Widowed 4 □ Divorcød 12. Was Decedent Amed Forces? 1 □ Yes 2 ☒ If Yes, Give Year or Dates:	No If		ic Origin? (Specify Yes or N ixican, Puerto Rican, etc.) ecify:	o- 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than *natural', or items 23e or 28e-f show event, the Medical Examinar must be profiled at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 94)	(Give)	ent's Usual Occupation kind of work done during NOT use retired) maker	most of working	16b. Kind of Business/Industry
2 ام	Hygi Hygi other snt, L	Be Co	17. Father's Name (First, Middle, Last)	поше		Mother's Name (First, Middle	Own Home p, Maiden Sumame)
ylaı	should be ind Mental marked umatic ev	To E	Charles Moxley			Jane Vogt	
	~ 0 0 2		19a. Informant's Name/Relationship (Type, Print) Clark A. Torell (Husband)			umber or Rural Route Numb ., Darnestown	per, Cify or Town, State, Zip Code) MD 20878
ore,	of Health		20a. Method of Disposition	20b. Place of Dispos		Date	20c. Location · City or Town, State
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature → Foneral Service Licensee	Metropoli	tan Cremato	ry 10/25/04 Facility DeVol Fun	Alexandria, Virginia
Ba	Per Dep fmp any		Water Handel	10 Ga	East Deer	Park ₂ Bsiye	
4	Enysician /Medical		23a Pan1. Enter the disease, or complications hat caused shock, or lear failure. List only one cause on each limediate Cause (Final disease or condition resulting in death)	t the death. Do not entene.	r the mode of dying, suc	h as cardiac or respiratory a	Approximate Interval Between Onset and Death
ľ	Examiner			a consequence of):			
	ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figury that initiated events c.	a consequence of):			
68/60,	ificate be executed ig physician and as the burial-transIt	edical Exa	that initiated events resulting in death) Last C. Due to (or as	a consequence of):			
O. Box 68	The law requires that the death certific, te has been signed by the attending plage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death b	ut not resulting in the un	derlying cause given in P		tobacco use contribute to the cause of death? Yes 2 □ No 3 ☒ Probably 4 □Unknown
	(Q) LL	Completed				24a. Was auto perfc 1 \(\subsection \text{Yes}	psy prior to completion of cause of death?
VITAI	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatient		Place of Death (Check only of	one) dence 6 □Other (Specify)
n or	ding Phys h. After this funeral di	atlon; T	27. Manner of Death 1 X Natural 5 Pending (Month, Day	y 28b. Time of	28c. Injury at Work?		how injury occurred
DIVISION	or Attending after death. Director: After in by the funer	Certification	2 Accident investigation	ury - At home, farm, stre	M 1 ☐ Yes 2 et, factory, office		Street and Number or Rural Route Number, wn, State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical Ce	29a. Certifier (Check only one) 1 S Certifying Physician: To the best of and manner ste	examination and/or inve	occurred at the time, date estigation, in my opinion,	e and place, and due to the death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of pertifier	A A '-	29c. License numb	Der	29d. Date signed (Month, Day, Year)
	3		30. Name and address of pers in who completed cause of di	eath (Item 23a) (Tune 13	D 3563	35	October 25, 2004
			Joseph Kaplan, M.D. 9715 M		•	221, Rockvill	e, MD 20850
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Begistra	ar's Signature	Sparker		

			1 - State Registrar	State of Marylar	nd / Depai <i>Cert</i>	tment of Healti	n and M th	lental Hy	giene 0	04	35708
	Physic /Medi		1. Decedent's Name (First, Middle, Last) $ROBERT \qquad LEE$	THOMPSON,	SR.			2. Date of De Month	Day	Year	3. Time of Death
	Exami	ner	4a. Facility Name (If not institution, give a Genesis Health	Care - The	Pines	4b. City, Town, or Locati Easton			4c. County	of Death	
	Funeral Director		5. Social Security Number 260-42-0588 6. Sex 12 Usual Residence of Decedent	7. Age (In yrs. 8	**	If Under 1 Year If Under Months Days Hour	der 24 Hrs.	8. Date of Bir (Month, Da 9 / 2 / 1		9. Birthpl Coun Geor	
	e Maryland a-f show	ctor	MD 10b. County Talbe		y, Town or Loca	Easton				10	0d. Inside City Limits 1X□X/es 2 □ No
	ath with the 23a or 28	ral Director	19 Crabapple Co	ourt		10f. Zip Code 216	01		10g. Citizen of United		*
900	hours after death with the Maryland hours after death with the Maryland lural', or Items 23a or 28a-f show all Exant are invitibled at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	lf.,	as Decedent of Hispanic res, specify Cuban, Mexi		ecify Yes or No Rican, etc.)		ce - America ck, White, e y: B1a	etc.
Son 21215_0036	, na 72	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		(Give ki life. Do	nt's Usual Occupation nd of work done during n NOT use retired) n Farmer	nost of work	ing	Agricu		
Thompson	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. It. M. ADIGE.	To Be	17. Father's Name (First, Middle, Last) Rev. Willie T.			Ma	ry Lo	u Har			
≥	l and 2 sh lealth and im 27 is m har traum	l	19a. Informant's Name/Relationship (Ty) Toby Freeman/Dat	ıghter	19 Cr	Address (Street and Nur abapple C	t., E	laston	, MD	21601	<u> </u>
Robert	mit. Pages to artment of Hoortant: If ite injury or ot		20a. Method of Disposition 1	emoval from State Th	omas C	tory or other place) emetery	10/3	30/04	St.Mic	chae1	ls, MD
R G	permit. Departi Import. any inj		21. Signature of Funeral Service License		21	Name and Address of Fa 6 North M	ain S	st.,Fe	derals	il Ho	ome, PA , MD 2163
•	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line. Due for as a conseq.	_	the mode of dying, such	as cardiac c	or respiratory a	rrest,	1	Approximate Interval Between Onset and Death
68760		edicai Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cuestal Due to (or as a consequence) My perten	uence di);	neumon Mar acci	dint			a	lays yems
P O Box	death cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	Ideath 3□E	ctopic pregnancy other (specify)			23d. Dat	te of deliver	ry Day Year
ords P	w requires that been signed t		Part II. Other significant conditions con			erlying cause given in Pa	rt I.			ribute to the	e cause of death?
Becc	The law rate has be page 2 sh	Completed by	type 2					24a. Was autop perfo	rmed?	Were autoportion to compleath?	sy findings available apletion of cause of
Division of Vital Becords	ng Physician: The ter this certificate neral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1. Manner of Death 1. Natural 5 Pending	ospital: 1	ER/Outpatient 28b. Time of	0.1	Nursing Hon		ne) lence 6 🗆 Othe now injury occurr		
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	Special Control Cont	28e. Place of Injury - At ho building, etc. (Specify	me. farm. stree	M 1 ☐ Yes 2		28f. Location (5 City or Ton	Street and Numbern, State)	er or Rural	Route Number,
	ha Hospital or A n 24 hours after he Funeral Dirac pletely filled in by	edical	29a. Certifier (Check only one) 12 Certifying Phys 2 Medical Examin	ician: To the best of my knowar: On the basis of examinat and manner stated.	tion and/or inves	itigation, in my opinion, d	eath occurre	ed at the time, o	date and place, a	and due to t	the cause(s)
	To that within 2 To the complet	M	29b. Signature and title of certifier Signature	n pleted cause of death (Item 50 & Id (Item 8. Registrar's Signal		29c. License number	0	Č	29d. Date signed Octobus	25, (ay, Year) 2004
_			30. Name and address of person who con	npleted cause of death (Item 50 & Fd (I	23a) (Type, Pri	Avenue,	Ea.	ston.	MD S	460,	/
	Sta Registr	-	31. Date filed (Month, Day, Year) GCT 2 7 2004	2. Registrar's Signat	ure						

			1 - For Stata Registrar	State	of Mary	land / Dep <i>Ce</i>	artment o			ind M		iene 0 () 4	35709)
	0.		1. Decedent's Name (First, Middl	e, Last)	. 1	,					2. Date of Dea	th		3. Time of Death	
	Physici /Medio		Beatrice	- U	ノカノフ	1					October	Day ル	Year 2004	6:00 P	М
	Examir		4a. Facility Name (If not institution	n, give street and r	umber)		4b. City, Tov	wn, or L	ocation o	f Death		4c. County			
			University of	Maryland	1 Medic	al Sustem	130		imoi			19011	tim	vere City	/
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F		yrs. last birthday)		ear ays	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth		9. Birtho	place (State or Forei	ign
	Director		217-96-7373 Usual Residence of Decedent		86	Yrs.					JUN 18	1918	PA PA		
	land		10a. State 10b. County		100	c. City, Town or Lo	cation						1	Od. Inside City Limit	te
	Many 1 sh	ō	MD T	ALBOT		EASTO	N							XOXYes 2 □ N	
	the 28a	Director	10e. Street and Number			12010	10f. Zip Co	de			1	0g. Citizen of	Albat Cour		
	3a or	0	29518 NANCY ST											niy:	
	death ms 2	Funerail	11. Marital Status	12. Was De	cedent Ever		Was Decedent	L601	panic Orig	in? (Spe	cify Yes or No-		ISA e - Americ	an Indian.	
9	after or Ita	Ē	1 ☐ Never Married 2 X Marr	ied 1 Yes	2 7No		If Yes, specify	Cuban,	Mexican	Puerto	Rican, etc.)		ck, White,		
8	hours after death with the Maryland tural', or Itams 23a or 28a-1 show at Examiner must be notified at	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, (Year or	alve —		1□Yes ஆ∏	No	Specify:			Specify	WH:	ITE	
21215-0036	22 88	Completed	15. Deceden (Specify only highe:	t's Education	1)	16a. Dece	dent's Usual O	ccupati	ion ring most	of worki	na	16b. Kind of B	usiness/In	dustry	
2	within ene. than "r	цф	Elementary/Secondary (0-12)	7	(1-4or 5+)	life.	DO NOT use re	etired)	ing most	Or WORK	,9				
	e filed v Il Hygier othar ti		12	())		HOMEMAK						HOME		
anc	be fi	Be	17. Father's Name (First, Middle, HARRY KING	Last)				1.			(First, Middle, f		10)		
Ĕ	should be nd Menta markad maric av	2		T							ED OTTE				
Maryland	2 8 9		19a. Informant's Name/Relations.								l Route Number		State, Zip	Code)	
	s 1 and 2 if Health itam 27 i		ROBERT S. WHIT	F\HO2BYNT		295 b. Place of Dispo	18 NANC	Y S	T. E		N MD 2		O:t T.	31	_
altimore,	eg = 5		1 🔀 Burial 2 🗆 Cremation		n State	cemetery, crei	natory or other	r place)	1			20c. Location -	-		
ij	permit. Pa Departmer Important any injury once.		4 □ Donation 5 □ Other (S)21. Signature of Funeral Service		V	VOODLAWN	MEMORI	AL :	PARK	10-	18-2004	EASTON	, MAF	RYLAND	
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			23a. Part1. Enter the disease, or	complications that		37- 2	10 S. H	ARR.	TSON	CT	MOTO A T	MD 216	01		
			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.		0					151,		Approximate Interval Between Onset and Death	
	Pn ysicia n /Medical		disease or condition resulting in death)	_a_/45		-710n	Procu	mo	mi	11	5			3 Days	
	Examiner			T Due to	/eu	sequence of):								4 12	
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	cuted	Examiner	Cause (Disease or injury that initiated events												
o Ô	an ar irial-ti		resulting in death) Last	Due to	(or as a con	sequence of):									
8760,	icate be executed physician and s the burial-transit	dicai		d											
9	artifica ing pl	Med	IF FEMALE:												
Вох	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	utcome of pre		Ectopic pregna	ancy					e of delive	2	
0	ne dea the a hed fe	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Preg 9⊟Unk	nant at time	of death 5	Other (specify	v)				Mor	nth	Day Year	
<u>а</u> .	that the deatl ed by the atte detached for	by Physician/Me	Part II. Other significent condition	De contribution to	dooth but not	reculting in the	adaut dans an o	will			00 - 5:111	-			-
Vital Records,	The law requires that the death certifi tte has been signed by the attending, bage 2 should be detached for use as	d by	Dancesti		inco		idenying cause	given	m Pan I.		1 \(\text{Ye}			e cause of death? ably 4 \to Unknown	_
Ö	w requir been si should	ete	11								-				_
ğ	has has ge 2	Completed	Hypertens							_	24a. Was an autopsy	р	rior to con	osy findings available opletion of cause of	0
 				nellito	15						perform		eath?	2 No	
Z.		o Be	25. Was case referred to medical examiner?	Hospital:	/			04			Check only one		_		
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on	ding th. : After funer	tion	1 Natural 5 Pending 2 Accident investig	,	of Injury nth, Day Year	r) Injury	_ '	Work?	s 2 □ No		od. Describe not	w injury occurre	ed De		
Division of	l or Attanding after death. Diractor: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Plac	e of Injury - A	At home, farm, stre		= .			8f. Location (Str.	et and Numbe	or or Rural	Route Number.	
ā	al or	Certification:	4 ☐ Homicide determi	build	ding, etc. (Sp.	ecify)					City or Town,	State)		,	
	a Hospital or A 24 hours after 5 Funaral Dira 6tely filled in by		29a. Certifier 1 Certifying	Physicien: To th	e best of my	knowledge, death	occurred at the	e time,	date and	place, a	nd due to the car	use(s) and mar	nner as sta	ited.	
	To tha Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	ledical	37.07	xaminar: On the land mai	nner stated.	iiriation and/or inv	estigation, in m	ny opini	ion, death	occurre	d at the time, da	e and place, a	nd due to	the cause(s)	
	To the within To the comple	Σ	29b. Signature and title of certifier	m	10	0	29c. Lic			,		d. Date signed			
,			Janua 1	In	, ///	. 1).	u	//	ンメノ			ctube	r 12	2004	_
			30. Name and address of person w	who completed cau	ise of death (Item 23a) (Type, I	Print) 12,11.	tim	10.00	1	16-11-	1	/) h	1 2004	
	Sta	te	31. Date filed (Month, Day, Year)	32.	Begistrar's Si	onature		11111	~ ~ ~~	///	4-9100	c of	20		
	Registra	ar	OCT 14	2004	in	B. So	enter								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 35710

				Certific	cate of	Death		Reg. No.	4 33710
		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Dey Yea	3. Time of Death
	Physician	Richard Winkel					Octobe		
	/Medical Examiner	4e Facility Name (If not institution, give	street and number)			4b. City, Town, or			
	Examine	Manage Come of Boto	\m 0.0			Potomac		Montgome	erv
		Manor Care of Poto 5. Social Security Number 6. Se		last birthday) If U	Jnder 1 Year		8. Date of Bir		
	Funeral	15	dw 5□E	Yrs. Mo	nths Days	Hours Min.	. (Month, Da	ay, Year)	Birthplece (State or Foreign Country)
	Director	Usual Residence of Decedent	97				Mar. 2	20, 1907 G	Germany
	Pu ≱	10a. State 10b. County	10c. City	, Town or Location	n				10d. Inside City Limits
	denyl or		D - 1						1 ☐ Yes 2 No
	ect of a	Maryland Montgome 1	ry Pot	omac	of. Zip Code			10g. Citizen of What	Country?
	ifer death with the Me ir items 23s or 28s-1 s incer must be notified Funeral Director	13 - 13 - 13 - 13 - 13 - 13 - 13 - 13 -		10	- 1			rog. Citizeri oi vviiat	Country
	# 23 E	11801 Hayfield Cou			2085			United Sta	
		11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. Was I	Decedent of F , specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	Black, W	merican Indian, /hite, etc.
3		1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give	1□ Y	es 2⊠ No	Specify:		Specify:	
0200-61212	filed within 72 hours effer death with the Meryland Hygiene. Hygiene. Ther than "natural", or terms 23s or 28s-f show ent, the Medical Examiner must be notitled at e.c. the Medical Examiner Funst be notified at e.c. ompleted by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:						White
ភ	led within 72 ho ygiene. Yer than "natura It, the Medical I	15. Decedent's Edu (Specify only highest grad		16a. Decedent's (Give kind	Usual Occur of work done	pation during most of wo d)	rking	16b. Kind of Busine	ss/Industry
7	d within giene. r than r than	Elementary/Secondary (0-12)	College (1-4or 5+)						
7	Sold To		4	Self	Emplo			Dry Clea	aning
2	Be de H	17. Father's Name (First, Middle, Last)						, Maiden Surname)	
<u>a</u>	To F	Ernst Winkel				Christi	ne Hanse	en	
e S	Short Name	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Ad	dress (Street	and Number or R	ural Route Numb	er, City or Town, State	e, Zip Code)
Σ	27 is	Julianne Lawlor	(Daughter)	11801	Hayfie	1d Court	, Potoma	ac, MD 208	54
<u>6</u>	S E E	20a. Method of Disposition	20b. P	lace of Disposition	(Name of	00)	Date	20c. Location - City	or Town, State
2	1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1	1 St Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	t. Auburi			10/29/04	Auburn,	Maine
Baitimore, Maryiand	permit. Peges 1 end 2 should be filed will Depertment of Heelth end Mentel Hygien Important: If item 27 is marked other thy any injury or other traumatic event, the once.	21. Signature of Funeral Service Licens						neral Home	Haire
n n	mpo Depe	1 A H				er Park		iciai nome	
		Yoberle M.	Life			rg, MD 2			
		23a. Part. Enter the disease, or complete shock, or heart failure. List only or	ications that caused the deeth ne cause of each line.	. Do not enter the	mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
3	Physician		L						Onset and Death
1	/Medical	Immediate Cause (Final disease or condition	Aspiration P	neumonia					:
	Examiner	resulting in death)		r as a consequenc					1
	je je		Prostate Can	cer					1
	outec	Sequentially list conditions.	D	r as a consequence	e of):				
o	EX Ciel-t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Atrial Fibri	11ation					i
x 68/60,	certificate be executed ding physician and ise as the buriel-trensit.	I that initiated events	V	as a consequence	e of):				
8	g phy as the	resulting in death) Lest	·		,				ì
	Se din		_ Diabetes Mel	litus					
8	r requires that the deeth of the esten signed by the esten should be deteched for use the by Physician	Part II. Other eignificant conditions cor	atributing to doub but not recu	uting in the underly	ina causa air	en in Part I	23h Did	tohacco usa contribu	ute to the cause of death?
oj	y the checked	Partin Other eighthcant conditions con	itinbuting to death but not rest	nung in ure unden	ring cause giv	on in rait i.			Probably 410 Unknown
7	thet ed b dete						10	Tee ZLING SL	Probably 489 Olikilowii
vital Records,	law requires that as been signed b 2 should be dete						24a. Was	an autopsy 24	b. Were autopsy findings
Ö	requision requisions and requisions are requisional and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions are requisional and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requisions and requision							ormed?	available prior to completion of cause
e e	The law requir								of death?
_	vysician: The law his certificate has be I director, page 2 s						10	Yes 23tNo	1 ☐ Yes 2 ☐ No
	Physician: rthis certific ral director, r. To Be (25. Was case referred to medical examiner?					ath (Check only	one)	
_	Physic this ce al dire	1 ☐ Yes 2 🔯 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Oth	ner: 4🖾 Nursing I	Home 5□ Resi	dence 6 □Other (S	pecify)
0		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo	ry at rk?	28d. Describe	how injury occurred	
0	ath. r: Ath	1 X Natural 5 Pending 2 Accident investigation	(,,	N		Yes 2 □ No			
DIVISION	Atte	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fa	actory, office		28f. Location (Rural Route Number,
5	tal or Attending P rs effer death. si Director: After t led in by the funers Certification:	4 I Homode	building, etc. (opecn)	,			uny un 7 un	, 5.5.6,	
	• Hospital or Attending Pl 124 hours after death. • Funeral Director: Attent letely filled in by the funeral edical Certification:	29a. Certifier 1 Certifying Phys	sician: To the best of my know	wledge, death occu	rred at the tir	me, date end place	e, and due to the	cause(s) and manner	as stated.
	he Hospit in 24 hour he Funer pletely fill edical	(Check only 2 Medical Exami-	ner: On the basis of examinat and manner stated.	ion and/or investig	ation, in my o	pinion, death occu	urred at the time,	date and place, and o	lue to the cause(s)
	within 2 To the comple	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
		cist: 1	9/10 m	1-12	D 20	127/		October 2	4 2004
	3	20 Name and address of sever its	emploted squee of death //*	22a) (Tuna Brint)		2/4		OCTOBEL 2	7, 2007
		30. Name end åddress of person who co	7710 Bradley			a. Mn 20	817		
		Kirti Hohra, MD 31. Date filed (Month, Day, Year)	32. Registrar's Signa		- 49		017		
	State Registrar	OCT 26 200	1 Departure	D A	packs				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Thom: AsState of Marylands/Department of Health and Mental Hydiers O. O. I.

Ŋ			1- State Registrar	Ce	rtificate of	neaith and M Death	ental Hygle Reg.		35711
	Physici	an	1. Decedent's Name (First, Middle, Last) Angela Marie Welch				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, o	r Location of Death	October	22, 2004 4c. County of Death	7:41p M
			Route 75 @ Davley Road I		New Mai			Frederick	
	Funeral Director		233-23-5252 1 M 2 Take	Age (In yrs. last birthday) 22 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Man Ye	ear) 1982 ^{9. Birth}	lace (State or Foreign try) VA
	yland sow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			1	Od. Inside City Limits
	e Mar 8e-f el	ctor	MD Frederick	New	Market				1XYes 2□No
	ath with the 236 or 2	Funeral Director	10e. Street and Number 26A W. Main St.		10f. Zip Code 217	14	10g.	Citizen of What Cour USA	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f ehow any injury or other treumatic event, the Medical Examinations to other promitted at once.	by Fune	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced	s? ∑No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Tith	etc.
2-00	72 hou natura ilcal E	eted	15. Decedent's Education (Specify only highest grade completed)	16a Decer	dent's Usual Occup	ation	16b	. Kind of Business/Ind	ite
Maryland 21215-0036	within ene. than *	Completed	Elementary/Secondary (0-12) College (1-40	71 3 +)	erk	during most of working 1)		onvenien	an store
nd 2	e filed al Hygi I other vent, I	Be Co	17. Father's Name (First, Middle, Last)	C1	.61.K	18. Mother's Name			ce store
ylaı	12 should be f and Mental I 7 is marked of reumatic eve	To E	Daryl Jennings				ia Wrig		
	and 2 sh ealth and n 27 is n		19a. Informant's Name/Relationship (Type, Print) Patricia Cole (Mother	5704	Mill R	un Pl.,	Route Number, Cit Frederi	by or Town, State, Zip \mathtt{ck} , \mathtt{MD} 2	^{Code)} 1703
Baltimore,	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	te Reforme	osition (Name of matory or other place d Cemeter	ery 10/3		Location - City or To ${ m d.dletown}$	
Balt	permit. Departimport Import any inj		21 Sign white of Funeral Sphio Cicerse) D	onaid 1 E. Ma	in St.	on Fune: Middlet	ral Home	21769
ļ	缺		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not enti-	er the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
H	Physician / /Medical			PLE TMU as a consequence of):	rus				Onset and Death
	Examiner			is a consequence on,					
	pet tisu	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Unsease or muny	as a consequence of):					
o,	rtificate be executed ng physician and as the burial-transit		that initiated events	as a consequence of);					
68760,	cate be	Medical	d						
P.O. Box 6	ath cer ttendir or use	Physician/Me		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year
	res that the de igned by the a be detached f	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause give	an in Part I.	23e. Did tobacco	use contribute to the	cause of death?
ecords,	w require been sig should be						1 ☐ Yes	2 No 3 Proba	bly 4 Unknown
Reco	The law rate has be page 2 sh	Completed					24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
Vital R	E FE DO	Be	25. Was case referred to medical examiner?			26. Place of Death (
o	Phys this ral dii	lon; To	XXYes 2 No Hospital: 1 Inpa 27. Manner of Death 1 Natural 5 Pending Amonth, D (Month, D	jury 28b. Time of Injury	28c. Injury Work	at 28	d. Describe how in	-	
Division	r Attendi er death. rector: A by the fu	Certification;	2 Accident investigation 10~20 3 Suicide 6 Could not be determined 28e. Place of I	niury - At home, farm, stre				and Number or Rural	Route Number
٥	spital or ours afte neral Dire	Cert	4 Homicles building,	etc. (Specify)		13	City or Town, Sta	you Franki	rice pro
	Ho Fur ely	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the basis and manner and manner series.	of examination and/or inv	occurred at the time restigation, in my op	e, date and place, an inion, death occurred	d due to the cause(at the time, date a	s) and manner as sta nd place, and due to t	ted. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License			ate signed (Month, D.	
		106	Mayorte Meller	ll	OCMI	E	Oct	tober 23,	2004
	3		30. Name and address of person who completed cause of	death (Item 23a) (Type, F		n Street,	Baltimore	e, Marylan	d 21201
	Stat Registra			trar's Signature	1. 1	ak)			
	- riegisti <i>c</i>	ú	001 % 0 Th04	1	100	CARA/			

			1 - State of Maryla	and / Depa	artment of Health and rtificate of Death	Mental Hygie	ene 2004	35712					
	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> Joan Davis Wenrich			2. Date of Death Month October	Day Year 21 2004	3. Time of Death 3:52 p.M					
	Examir Funeral	er	1 M 2 ME	rs. last birthday)	4b. City, Town, or Location of Dea Cambridge If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth	4c. County of Death Dorchester inth lay, Year) 9. Birthplace (State or Foreign Country)						
D	Director	J.	210-42-4521 61 Usual Residence of Decedent 10a. State 10b. County 10c.	9 Yrs. City, Town or Lo		April 29	, 1935 E	ngland 10d. Inside City Limits 1 □ Yes 2 ☑ No					
J. A. Mitter Market Mar	and Montal Hygiene. marked other then "neturel", or Items 23e or 28e-1 show umatic event, if e Madical Exeminer ought by natified at	Directo	MD Dorchester 10e. Street and Number 110 Holly Terrace		Cambridge 10f. Zip Code 21613	10g	10g. Citizen of What Country? U.S.A.						
936 28		by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic Origin? (stif Yes, specify Cuban, Mexican, Puel	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh:	etc.					
Maryland 21215-0036 C. Should be illed within 72 hours after death with the Maryland	jiene. r then "neture It e Madical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) homemaker	ne during most of working ired)							
	d Mental Hyg marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last) Benjamin Franklin Davis 19a. Informant's Name/Relationship (Type, Print)	19h Maili	me (First, Middle, Ma Jannah Kett								
os 120d2s	Department of Health and Menta Importent: If item 27 Is marked eny injury or other traumatic es 80cs.		Steve Wenrich sol	n 512 D. Place of Dispondentery, crem	W. Main St., Way osition (Name of matory or other place)	mesboro, I	PA 17268 c. Location - City or T	own, State					
Baltimore,	Department Importent eny injury		21. Signaturi of Funeral Service Licensee	70	y Crematory 110/2 2. Name and Address of Facility T 200 Locust St., Ca	homas Fune mbridge, M	ID 21613	Æ.A.					
	nysician /Medical		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Beh Inte										
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed to the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										
	y the attending pt ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown		23d. Date of delivery Month Day Year								
	been signed b	by	Part II. Other significant conditions contributing to death but not r	/	Did tobacco use contribute to the cause of death? 1 2 Yes 2 No 3 Probably 4 Unknown								
		e Completed	25. Was case referred to medical		autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No								
	ter this	To B	examiner? 1	2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
DIVISION Hospitel or Attending	ours after death. eral Director: Al filled in by the fu	il Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	ocify)		ul Route Number,							
To the Hos	within 24 hours after To the Funeral Directory completely filled in b	Medicai	(Check only 2 Medical Examiner: On the basis of examinand manner stated. 29b. Signature and title of certifier	29c. License number			te to the cause(s) and manner as stated. the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)						
•			30. Name and address of person who completed cause of death (It David H. Smith M.D.				21601						
	Sta Registr	_	31. Date filed (Month Day, Year) 2004 328 Registrar's Sig	nature	5 Pintail Dr., Eas	SCOI, MD	21601						

				artment of Health and Ment	tal Hygien		35713							
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 12.10 PM										
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death								
			730 Dill Road	Severna Park		Anne Aru	ındel							
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 N F 7. Age (In yrs. last birthday, 99 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Do Norths Days Hours Min. 04 04 04 04 04 04 04 0	ate of Birth fo <i>nth, D</i> ay, Yea 4/24/19(9. Birthplac Country	ce (State or Foreign MD							
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		Lea								
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or othar traumatic evant, I to Medical Examinar must be notified at once.	ctor	MD Anne Arundel	Severna Park		100	Inside City Limits 1 ☐ Yes 2X No							
	with the	I Director	10e. Street and Number 730 Dill Road	10f. Zip Code 21146	10g. C	Citizen of What Country USA	1?							
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,	es or No-	14. Race - American								
36	irs after II, or Ita	by Fu	1 Never Married 2 Married 1 Yes 2 XNo	If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:	, etc.)	Black, White, etc	ite							
9	72 hou		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Indus	stry							
2	ithin Je.	Completed	(Specify only highest grade completed) (Give life.	kind of work done during most of working DO NOT use retired)										
22	iled w Hygier ther th		12 17. Father's Name (First, Middle, Last)	Homemaker 18 Methodo None (5)	A 46'-14'- 14-14-	Home								
yland	Mental Mental arkad o	To Be	Ernest B. Myers	18. Mother's Name (First	i, Middie, Maide	an Sumame)								
Mar	nd 2 shoulth and 27 is ma			ng Address (Street and Number or Rural Rout Dill Road, Severna I			ode)							
Baltimore, Maryland 21215-0036	ges 1 ar t of Hea if itam or otha		20a. Method of Disposition 20b. Place of Disposition comptany, cre	osition (Name of Date matory or other place)	20c. l	Location - City or Town								
altim	mit. Pa partmen portant: r injury 20.		21. Signature of Euneral Service Licensee	2. Name and Address of Facility	004	Annapolis,								
<u>~</u>	Depa Impo any ir		Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146											
			23a. Part1. Enforme disease, or confolications that caused the death. Do not en shock, or heart ailure. List only one cause on each line	ter the mode of dying, such as cardiac or resp	iratory arrest,	Aj	oproximate terval Between nset and Death							
di .	Physician /Medical		disease or condition resulting in death) a	Heaf tom we			840							
	Examiner		Cha	Atrial F. brillo	riun		1040							
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. HIPCHOJ.											
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38760	death certificate be executed e attending physician and of for use as the burial-transit	dlcal	d											
ox 6	= 120 cm	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery								
Ö.	the atte	Physiclan/M	in the past 12 months?	Ectopic pregnancy Other (specify)		Month Day Year								
٥.	res that the digned by the be detached	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23	3e. Did tobacco	Did tobacco use contribute to the cause of death?								
Hecords,	The law requires that the te has been signed by the page 2 should be detached	o Be Completed by	DEMENTIA		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown									
Tecc	has be			24	la. Was an autopsy	24b. Were autopsy prior to comple	findings available etion of cause of							
Vital			25. Was case referred to medical		performed? ☐ Yes 2 No	death? 1 ☐ Yes 2 ☐] No							
	ysician: is certific director,		examiner? 1 Yes 2 SNo Hospital: 1 Inpatient 2 EP/Outpatien	26. Place of Death (Check t 3 DOA Other: 4 Nursing Home	(Check only one) ne ⇒ lesidence 6 □Other (Specify)									
n of	ding Phys h. After this funeral di	P Control (Openly)												
<u>S</u>	tendii Beath. Tor: A the fu	catio	2 Accident investigation	M 1 Yes 2 No										
Division	after after control Dirac	Certification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) Medical Examinar: On the basis of examination and/or income.	o occurred at the time, date and place, and due restigation, in my opinion, death occurred at the	e to the cause(s	s) and manner as stated	d.							
	To tha Hos within 24 h To tha Fun completely	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		ite signed (Month, Day								
	- s + ŏ		M & Grundy	D0021703)	0/25/7	4004							
			30. Name and address of persog vho completed cause of death (Item 23a) (Type,	Print)	/ A \	Res 4	40.							
	Stat	te	31. Date filed (Month, Day, Year) 5 2004 32. Highstra's Signature,	51 Ft Smill word	rd rel	rannoler	21122							
	Registra	ar	OUI GO COUT THE TO											

				For State Registrar		State o	f Maryla	nd / Dep <i>Ce</i>			lealth Death		lental Hy	gien Reg. N	2004	3571	4
1. Decedent's Name (First, Middle, La													2. Date of Death			3. Time of Death	
	Physician /Medical Dorothy C. Alexander												Month			16:50 P	М
		Examir		4a. Facility Name (If not institution)	on, give s	treet and nur			_		r Location	of Death			c. County of Deatl	1	
				Sinai Hospit	<u> </u>		iltim		+ -	or 1 Year	More	r 24 Hrs.	ity				
-		Funeral Director		5. Social Security Number	6. Sex	м 21,7 Г		s. last birthday) Yrs.	Month		Hours	Min.	8. Date of Bi (Month, Da	ay, Year	Coi	nplace (State or Foreig untry)	
8				580-14-2886 Usual Residence of Decedent			7.8					1	01/19/	192	6 Virg	in Islands	<u>. </u>
ð		rylan	_	10a. State 10b. Count	У			City, Town or Lo								10d. Inside City Limit	
exand		death with the Maryland ms 23a or 28a-f show	Director	Maryland											¹¶ Yes 2 □ N	0	
Á				10e. Street and Number 10f. Zip Code						_	itizen of What Co	untry?					
1)		Funeral		4922 Lanier Avenue Apt. B 11. Marital Status 12. Was Decedent Ever in U.S.				21215 13. Was Decedent of Hispanic Origin? (Specify Yes or						.S.A. 14. Race - Amer	ican Indian.	_
3	ဖွ	or Iter	臣	Armed Forces? If Yes, specify Cuban, N I						an, Mexica	in, Puerto	Rican, etc.)		Black, White	, etc.		
Dorat	215-0036	ours a	d by	3 Widowed 4 □ Divorce	3 ₩idowed 4 Divorced If Yes, Give Year or Dates:									Specify: B1	ack		
O	5-("natu	Completed	15. Decede (Specify only high	nt's Educ est grade	cation completed)		16a. Dece (Give	dent's Us	ual Occup vork done	ation during mos	st of work	ing	16b. l	6b. Kind of Business/Industry		
	7	withir ene. than	E C	Elementary/Secondary (0-12)		College (1	-4or 5+)				<i>a)</i>						
ž	d 2	filed Hygi other	Be Co	Unknown 17. Father's Name (First, Middle	, Last)			Hous	sewif	e	18. Moth	er's Name	(First, Middle		nemaker n Sumame)		
ζ	Maryland	uld be Aenta rked tic ev	To B	Louis Dusauza	У					!	Umi	ce Da	arcie				
3	lan	2 sho and h is ma	ľ	19a. Informant's Name/Relation	ship (Typ	oe, Print)		1						-	or Town, State, Z		Ŋ
کے		and ealth m 27 her tr		Francis Dusauz	ay /	Son							-			yland 2121	.5
华	lore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan School of Pepartment of Health and Mental Hygiene. Continuous mportant: If item 27 is marked other than "natural", or flems 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.		20a. Method of Disposition 1 √Burial 2 ☐ Cremation		emoval from	State 20b.	Place of Dispo cemetery, crea	osition (N matory o	ame of other plac	э)		Date	20c. L	ocation - City or T	Town, State	
Patient	Baltimore			 4 ☐Donation 5 ☐ Other (21. Signature of Funeral Service) 			Mt	. Zion			1	1/12	/2004	Land	dsdowne,	Maryland	_
G	Ba				D U	1		Ι.	A.							Funeral Ho	me
•			-	23a. Part. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proximale													
				shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only on	A cause on e	ach iine.	,								Onset and Death	
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	68760,	cate be execu physiclan and the burial-trai	dical														,
				IF FEMALE:													- 1
	30X	death certifics attending pt d for use as t	an/h	23b. Was decedent pregnant	23	3c. If yes, out 1□Live b	come of pregr irth 2 ☐ Fet	nancy tal death 3	Ectopic	pregnancy					23d. Date of delive	ery Dav Year	
Was decedent pregnant in the past 12 months? O'therefore the past											WOTET	Day real					
		res that the dei signed by the a be detached f		Part II. Other significant condit	ions con	tributing to de	ath but not re	sulting in the u	nderlying	ing cause given in Part I. 23e. Did tobac					cco use contribute to the cause of death?		
g g Diabetes Mellitis								10	1 Yes 2 No 3 Probably 4 d Onknown								
	000	Display to the pertension 1 yes 1 yes 14a. Was an autopsy								24b. Were autopsy findings available							
	Piabetes Mellitis The part of the significant continuous continuous to death out not resulting in the underlying cause given in Part i.								rmed?	prior to completion of cause of death?							
	'ita	Attending Physician: The law requires that the death certif reath. rdeath. sctor: After this certilicate has been signed by the attending by the funeral director, page 2 should be detached for use a	Bec	25. Was case referred to medic examiner?	al						26. Place	e of Death	Check onl		,	20110	
	of V		은	1 ☐ Yes 2 ☑ No	Hospital:						ne 5□ Resi	5 Residence 6 Other (Specify)					
	S LC		lon:	27. Manner of Death 1 Natural 5 pending 2 Accident investigation 3 Suicide 6 Could not be determined 1 Manual 28b. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred								8d. Describe how injury occurred					
	isic	or Attendi after death. Director: A in by the fu	flcat									al Route Number.	-				
	Div	al or after	Certification;	4 Homicide	mned	building, etc. (Specify) City or Town, State)									Ŋ		
		To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
		To the within 2 To the complet	Mec	29b. Signature and title of certifi	er 🙍	and manr	ioi sialed.		2:	9c. License	e number			29d. Date signed (Month, Day, Year)			
Ata Hohis Mi							MD					201	30 November al of Baltin			8,2004	
		B		30. Name and address of person	who co	npleted caus	e of death (Ite	m 23a) (Type,	Print)	100	J. L			J-5 V			
1		U		Suzan F		ohe		D Si	nai	Ho	spi	tal	40	Bo	Utimo	ore	
		Sta Registr	4	31. Date filed (Month, Day, Year NOV 1 2	200	4 32.R	gistrar's Sign	nature	Sp	out.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Megan Dawn Arnold State of Maryland / Department of Health and Mental Hygieng 004)4 - 71751 - For State Ragistrar DOS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** egan)awn 0000 a M November 6, 2004 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 Staghorn Court #F Cockeysville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, OCT, C) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 201F 220-13-9379 Director TOWSON Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at Cockeysville Ba Himor 1 ☐ Yes 2 No Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or itams 23a or U.S.A. HOM 21030 Cour 6 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc within 72 hours after 1 Never Married 2. Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify: White δ 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mary land nit. Pages 1 and 2 should be filed withir artment of Health and Mental Hygiene. orient: If Itsm 27 is marked other than injury or other traumatic event, Itsm Ms Elementary/Secondary (0-12) College (1-4or 5+) Club minis NA 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mann Kevin 19b. Mailing Address (Street and Number or Rural Route Number, 327 Hotmann 20b. Place of Disposition (Name of cemetery crematory or other) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If any injury or once. Evans Funeral Chapel Bel Ax 21. Signature of Funecal Service Funeral + Cremation Ch for tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only doe cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asplyxia strangula from du to Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the ettending physician and the for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year detached for Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No 1 X Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Nother (Specify) at SCENE Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of P To the Hospitel or Attending I within 24 hours after death.
To the Funerel Director: After 1 Natural 5 Pending Subject strongled 11/5/04 23:55 1 ☐ Yes 2 X No 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 X Homicide Home 6 staghorn Ct. #F, Cockeysville, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) **OCME** November 6, 2004 ss of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Registrar
DHMH 17 Rev 1/2001

souls

32. Registrar's Signature

Kefauver Adams Baltimore, Maryland 21215-0020 narcelene Box 68760.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 35716 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Worth Dey Physician Year Marcelene Kefauver Adams 2004 1:5517 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Nursing Home Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min. Director 220-40-8119 89 Apr. 21, 1915 Maryland Usuel Residence of Decedent filed within 72 hours efter daath with the Marylend Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1410 Calvary Road 21015 USA or items 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: ş Specify. 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 end 2 should be fil of Health end Mentel H itam 27 is marked ott Be Luther Melvin Kefauver Esther Etta (nmn) Easterday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas L. Adams, Jr. / Son 1408 Calvary Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Depertment of important: If it any injury or or p Burial 2 ☐ Cremation 3 ☐ Removal from State Churchville Presbyterian 11-10-04 Churchville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical End-Stage Pranic demention

Due to (or as a consequence of): 6 mantles. Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Slonie carcinoma 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records. ģ Be Completed 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral directors. 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide

Certification: To

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) Mu babelle November 8, 2004

Registrar

7. 18 ABOLE 31. Date filed (Month, Day, Year) 2 2004

MACGREGOR, 700 W. 32. Registrar's Signature

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

regor 171)

113657

40 th STREET, BAUTIMORE, MD. 21211

			For State Registrer	State of Ma	arylar	nd / Depa	artment of H	lealth a Death	ind Me	ental Hyg	giene (004	357	17.
	Physici	an	Decedent's Name (First, Middle, L.	. Burg	PC	ς				2. Date of Dea Month	ath Day	Year	3. Time of	
	/Medic Examin		4a. Facility Name (If not institution, gr		ر ب		4b. City, Town, o	r Location of	f Death		0 6 4c. Co	QOO LA	9 47	<i>[7</i> ···
	LAGIIIII	Ç1	GOOD SAMARE		3 P I	TAL	BAL-		OR	E		NA		
	Funeral		Social Security Number 6.		Θ (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birtl (Month, Day	h v, Year)	9. Birthp	lace (State c	or Foreign
	Director		244-12-3098 Usual Residence of Decedent	I AM ZUF	84	Yrs.				9-12			N.C.	
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside Ci	ity Limits
	Mary F sh	tor	Md. NA			Balt	imore						1 🔀 Yes	2 🗌 No
	or 28¢	Director	10e. Street and Number				10f. Zip Code				10g. Citizer	of What Cour	itry?	
	23a c		2637 Grogan Ave				2121	3				USA		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 Is marked other then "naturel", or Items 23a or 28e-f show or other traumatic event, it is Medical Exact must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married	12. Was Decedent Armed Forces? 1 Ves 2 1 If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Orig in, Mexican Specify:	jin? (Spec , Puerto R	cify Yes or No- lican, etc.)		Race - Americ Black, White,	etc.	
21215-0036	2 hou		15. Decedent's	Education			dent's Usual Occup				16b. Kind	of Business/Inc	dustry	
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Maryland	2 should be and Mental Is marked o	2	Robert 19a. Informant's Name/Relationship	(Tugo Print)	Bur	gess	ng Address (Street		uise	Pauta Numba	r City or Tr	Cheeks		
Ma	id 2 s ith an 27 Is i		William L. Burg	_) McClean						,	
Ē,	s 1 ar f Hea item 3		20a. Method of Disposition	, — — — — — — — — — — — — — — — — — — —	20b.	Place of Dispo	sition (Name of matory or other place	Ī		ite		ion - City or To	_	
9	Pages ient of nt: If i		1 Nation 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control Con				Forest V		11-15	5-04	Owin	gs Mill	s, Md	
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If item 27 It any injury or other tra once.		21. Signature of Funeral Service Lice	•			Name and Address		′	118alt		th Md.	21202	
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9	the death certificate be executed y the attending physician and Iched for use as the buriat-transi							·						
Вох	eath certific attending p	Physician/Me	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth			Ectopic pregnancy				23d	. Date of delive	*	
	se deat the att hed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			Other (specify)					Month	Day Y	/ear
P.O.	that the di ed by the detached	Phy	9 Unknown					and a Paral		an- Dida				
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Vital Records,		Completed								24a. Was a autops perfor	sv	4b. Were autor prior to cor death? 1 ☐ Yes	npletion of ca	available ause of
/ita	Attending Physicien: The r death. ectrificate h: ector: After this certificate h: by the funeral director, page	Be	25. Was case referred to medical examiner?	Lucaritati ((Check only or				
	Physi this c	10°	1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatier						Other (Specify)	
Division of	ding l	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	• Worl	∕aτ ⟨? Yes 2 □ N		3d. Describe h	ow injury oc	currea		
ısı.	Attender death	fica	3 Suicide 6 Could not	be 28e. Place of Injury	ury - At h	nome, farm, str	eet, factory, office			3f. Location (S	treet and N	umber or Rura	Route Numi	ber.
Š	el or /	Certification:	4 Homicide	building, et	c."(Speci	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town	n, State)			
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			Hinzosom	•			RIES	000	O		11/0	6/04	, â	
/	3/		30. Name and address of person who	completed cause of d	eath (Ite	m 23a) (Type,	Print)							
	0			IN GORAN	UI	560	ol Loc	H R	AVE	n Bi	VA.	BALT	MORE	E,MD.
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Sign	ature £	Sont	ø.			,			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 0 0 1 35718 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:30 /Medical 4a. Fecility Name (If not institution, give street and number) 6000 4b. City, Town, or Location of Death 4c. County of Death Examiner NA GENESIS HOMEWOOD BELLONA A VE 5. Social Security Number 6. Sex 12 Age (In yrs. last birthda BALTIMON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Z- Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 645-26-92 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Madical Examiner must be notified at Md. NA 1 XYes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 6000 Bellona Ave. 21212 natural, or Itams 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ifiled within 72 hours after de l'Hygiene. other than "natural", or Itam Black, White, etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: Black 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Welder 7th grade Pratt & Wittney Pages 1 and 2 should be filed venent of Health and Mental Hygies ant: If Item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earlee Brooks Minnie Faulkner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Ford 14 Cree Ct., Baltimore, Md. Niece 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite 1 Burial 2 Cremation 3 Removal from State '4 □Donation 5 MOther (Specify) Intombment Arbutus Mem. Pk. 11-11-04 Arbutus, Md 21. Signature of Funeral Service Licencee 22. Name and Address of Facility Baltimore, Md. 21202 Bemand 1101 E. North Ave. March F.H. East rymon 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 men resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner If any leading to immedicause. Enter Underlying Cause (Disease or injury the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Waknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 1 NO To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 persing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baldimore 308 821 10 Eulerio 31. Dale filed (Menth Registrar's Signature 1º2º2004 State Registrar

			For State Registrar	State of I	Maryland / De	partment of F ertificate of	lealth and <i>Death</i>		giene 004	35719
	Physicia		1. Decedent's Name (First, Midd Joseph Donald	, ,				2. Date of Dea Month	Day Year	3. Time of Death 3:09P. M
	/Medic Examin	er	4a. Facility Name (If not institutio	, ,	er)	4b. City, Town, o	or Location of Dea		4c. County of Dea	
	Funeral Director		5. Social Security Number 219–28–7858 Usual Residence of Decedent	6. Sex 7. 1 2 M 2 □ F	Age (In yrs. last birthda 72 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hr Hours Min		, Year) 9. Bi , 1932 Mai	rthplace (State or Foreign ountry) ryland
Melyce	fed at	tor	10a. State 10b. County Maryland n/a		10c. City, Town or Ba	Location ltimore				10d. Inside City Limits 1 Yes 2 No
di di	st be noti	Funeral Director	10e. Street and Number 910 W. Lombard			10f. Zip Code 21 223			10g. Citizen of What C United Sta	
5-0036	popurment of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23e or 28e4 shov any injury or other treumatic event, the Medical Examination ust be confined at once.	by Funera	11. Marital Status 11☑ Never Married 2☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	es? X No	B. Was Decedent of I If Yes, specify Cub	dispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	giene. er then "netu	Completed by		nt's Education st grade completed) College (1-4d	(Gi	cedent's Usual Occup ye kind of work done . DO NOT use retire Stuffer	during most of w	orking	16b. Kind of Business Newspa	
rland	Jental Hy rked othe tic event,	To Be C	17. Father's Name (First, Middle, Cecil F. Bush	Last)			18. Mother's Na Anna	ame (First, Middle, Cowan	Maiden Sumame)	
, Mary	alth and h		19a. Informant's Name/Relations Patricia Peeple	, , ,, ,					r, City or Town, State, ore, Maryl	
Baltimore,	nent of He int: If Item iry or oth		20a. Method of Disposition 1 □ Durial 2 □ Cremation 1 □ Donation 5 □ Other (S		cemetery, c	position (Name of rematory or other pla Park Ceme			20c. Location - City of Baltimore,	
Balti	Departm Importa any inju		21. Signature of Funeral Service	Lion See Zin					neral Home more, Mary	, Inc. land 21229
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O. Box 6	y the attending packed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal death 3 t at time of death 5	□Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
ords, P	5.6	by	Part II. Other significant conditi	ons contributing to deat	h but not resulting in the	underlying cause gr	ven in Part I.		bacco use contribute t es 2□No 3□P	o the cause of death?
I Rec	ate has b	Completed						24a. Was a autops perforr	ned? death?	utopsy findings available completion of cause of
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of of	er this neral dii	atlon: To	1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Natural investi	28a. Date of I	A.,	of 28c. Inju	ry at		ence 6 Other (Spe ow injury occurred	ecify)
-	in Sire	Certification:	3 Suicide 6 Could 4 Homicide determ	rined 286. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
J Joseph ed	in 24 hou the Funer pletely fill	Medical	29a. Certifier 1 Certifyii (Check only one)	ng Physician: To the be Examiner: On the basis and manner	s of examination and/or	investigation, in my o	ppinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
Tother		2	29b. Signature and title of certifie	N. 12	fa	29c. Licens			9d. Date signed (Mon.	
	ix		30. Name and address of person		of death (Item 23a) (Typ	e, Print)			OVEMBER 8,	
	Sta Registr	te	Margarita Korel 31. Date filed (Month, Day, Year,	2 Regi	strar's Signature	111 Penn	_Street,	Baltimo	re, Maryla	nd 21201

State of Maryland / Department of Health and Mental Hygiens 35720 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Month BRIGHT **Physician** 204 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GLEN If Under 1 Year Birthplace (State or Foreig Country) **Funeral** Days Min 1 M 2 □ F JAN 15,1932 26. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b Count 10d. Inside City Limits 123a or 28a-f ahor BALTIMORE CIT BALTIMO 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Cod 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tent of Heatth and Mental Hygiene. Int: If item 27 is markad othar than "natural", or items 23a or 2 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: African American Specify: If Yes, Give Year or Dates: traumatic avant, the Mudical Example 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BALTO, CITY PUBLIC DHOUS IRS OORDINATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HENRY WILLIAM ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 290 itam 27 i 3 FOREST GLENN RD MARVE. BRIGHTFUL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o Department of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses JR. FUNERAL HOME BALTO. MD. 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Year disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To tha Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Box 68760. Physician/Medical the IF FEMALE esn. 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No , page 2 s 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes P 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural death. 1 Tyes 2 No 2 Accident investigation after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To tha Funeral E completely filled i 29a. Certifier 1/= Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier (Item 23a) (Type, Print) WOY 31. Date filed (Month, Day, Year) State NOV 1 2 2004 Registrar

			1 - For State Registrar	State of Marylar		t of Health and e of Death	Mental Hygiene	2004	35721
	Physici /Medic Examin Funeral Director	cal	5. Social Security Number 6. Sec 220-20-9206	beth street and number) ey Rd.	B	Town, or Location of Deat Typear If Under 24 Hrs Days Hours Min.	,	County of Death	3. Time of Death A M M M M M M M M M M M M M M M M M M
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at Once.	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 19a. Info mant's Name/Relationship (Ty 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	12. Was Decedent Ever in Under Armed Forces? 1	If Yes, special of Yes, special of Yes, special of Disposition (Name an OSEP)	James of Hispanic Origin? (Street and Number or Rules of Address of Facility Address of Facility Address of Facility Address of Facility Address of Facility	pecify Yes or No- o Rican, etc.) Thing 16b. K The (First, Middle, Maiden Per And Parte 2004 The 2004 The Example 1500. Lec The Ex	14. Race - America Black, White, e Specify: Black Clind of Business/Ind Sumame) Cor Town, State, Zip Cocation - City or Town, Management	an Indian, etc. ACK Justry Stic Code) Md, 21133
,097	Physician / Medical Examiner physician and physician supplies the private physician ph	ical Examiner	shock, or heart fafure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	Autorition (control of):	Lecture.	or respiratory arrest,		Approximate Interval Between Onset and Death
cords, P.O. Box 68	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions cor	3c. If yes, outcome of pregnation of the control of	al death 3 □Ectopic prodeath 5 □ Other (sp	ecify)		use contribute to the	Day Year
от Vitai не	To the Hospitel or Attending Physician: The law ro thin 24 hours after deal within 24 hours after deal with a function of the Funerel Director: After this certificate has be completely filled in by the funeral director, page 2 sho	Certification; To Be Completed	25. Was case reterred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 28a. Date of Injury At hundring, etc. (Specification)	Injury M ome, farm, street, factory	A Other: 4 Nursing H 8c. Injury at Work? 1 Yes 2 No	24a. Was an autopsy performed? 1 Yes 2 No th (Check only one) ome 5 N Residence (28d. Describe how injure) 28f. Location (Street an City or Town, State)	prior to comdeath? 1 Yes 2 6 Other (Specify) y occurred	
	V	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who co	inician: To the best of my knother: On the basis of examinal and manner stated. mpleted cause of death (Item	n 23a) (Type, Print)	at the time, date and place in my opinion, death occu License number	29d. Dat	d place, and due to the signed (Month, Di	the cause(s)
4	Sta Registr		NOV 1 2 2004	De la la la la la la la la la la la la la	Speck				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes 35722 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 6, 2004 Year **Physician** 1:10P Alta Mae Beall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day Year) April 22, 1917 Washington DC 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 1□ M 2√X Months Days Hours Min 578 24 3539 87 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or than "natural", or frams 23a or 28a-f show the Medical Examiner must be rediffed at 1 ☐ Yes 2/No Director Upper Marlboro Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1657 Richie Marlboro Road 20774 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A.A. Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: Specify White 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Register of Elections P.G. County Gov't nd 2 should ba filad afth and Mental Hygis 27 Is marked other raumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Owings John E. Beall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Azalea Lane, Leesburg, F1 34788 19a. Informant's Name/Relationship (Type, Print) permit. Pagas 1 and 2 sh Department of Health and Imp. rtant: If Item 27 Is m any injury or other traum <u>once.</u> Phyllis A. Horn (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery Nov 10, 2004 Suitland, Maryland ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuheral Service Licenses 22. Name and Address of FacilityLee Funeral Home, Inc 6633 (11) Alexandria Ferry Rd, Clinton, MD 20735 340 23a. Part 1. Enter the disease, or cord, Lations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COVONAVY avter-**Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner arnal wowe cause trail, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the burial-transit evipleval Due to (or as a consequence of): Physician/Medical usa as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for signad by the a d be detached fo 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 No 2 No 1 Yes 1 Yes After this certification funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 EP/Outpatient 3 DOA Other 0 1 Tyes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D4204 November 8, 2004 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Marilboro. ma 10 Champaloux 6 31. Date filed (Month, Day, Year) NOV 1 2 2004 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

filad within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

			For State Registrer	State of Maryland	l / Depa <i>Cen</i>	rtment of H	lealth and M Death			35723
			Decedent's Name (First, Middle, Last,					2. Date of Dea	_	3. Time of Death
	Physici /Medi		GEORGE ALBE	RT BOYCE				NOVEMBE	ER 10, 20	04 03:43P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of	Death
			VA MARYLAND HEALTH			PERRY P			CECIL	
6-2	Funeral		5. Social Security Number 6. Sec		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	Year) 9	. Birthplace (State or Foreign Country)
BOYCE	Director		Usual Residence of Decedent	78	115.			2 - 15	5- AZG	MARYLAND
8	yland		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
RT	Mar.	tor	MD BACTIM	ORE BA	LTIN	ORE				1 ☐ Yes 2 X No
ALBERT	or 28)lrec	10e. Street and Number			10f. Zip Code			log. Citizen of Wha	at Country?
AI	death with the Maryland ms 23e or 28a-f show mast be tolified at	ral	3400 NORTH	TRAIL WAY		212	-34		05	A
E	ar dex tems	Funeral Directo	3.4	12. Was Decedent Ever in U.S Armed Forces?		as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
GEORGE 3036	rs afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 □ No If Yes, Give Year or Dates: 44 -4	16 1	☐ Yes 2X No	Specify:		Specify:	L. NISTE
GB 6	2 hou		15. Decedent's Edu		16a. Decede	ent's Usual Occupa	ation		16b. Kind of Busin	ness/Industry
NN:	nin 77	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k	ind of work done a O NOT use retired,	turing most of work	ing	-	io o o mio o o m
21.A	d wit	mo:	8	Oonege (1 40/ 34)	SIE	AMFIT	TER		CONSTR	CULTION
SIC	d oth	Be (17. Father's Name (First, Middle, Last)	2			18. Mother's Name	e (First, Middle,	Maiden Sumame)	
PHYSI(Ment Ment Merice Merice	ို	CLIF ION	Dolle			FLOIE	Lis. gades	KIDW	ELL
Mar	12 sh h and 7 is rr		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailing	Address (Street a	and Number or Rura	al Route Number	City or Town, Sta	ate, Zip Code) 21234
	1 and Health 9m 27	1 8	20a. Method of Disposition	Ob Pla	S40	ition (Name of	IHIK	Date	20c. Location - Cit	IMPRE, IND
Z P	ages nt of nt of r or o		1 Burial 2 ☐ Cremation 3 ☐ F	temoval from State	metery, cremi	atory or other place	9) 11/12	/24 -	20c. Location - Cit	y or rown, state
E ENOWN Baltimore	perm I. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28a-f show any injury or other treumetic event, the Medical Escaping must be redified at ance.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			PAITH Name and Addres	s of Facility C	BOD HA	2500 PO	1, 1/10
BE	perm Depa Impo any i		1	M. 220	T	14150	Co. C. Califolio, Co. C.	T MEN		ALTIMOR, ND
NAME B			23a. Part1. Enter the disease, or compli	cations that caused the death.	Do not enter	the mode of dying				Approximate
_	Physician		Immediate Cause (Final	te cause on each line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):					ONE WEEK
	Examiner		Sequentially list conditions,)						
	'ם ו	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
An	ecute and -trans	Examiner	that initiated events resulting in death) Last							
60,	ficate be executed physician and s the burial-transit	E E	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a conseque	ince or);					
68760,	ficate be physicia s the bur	edical		i						
Вох	nding use a		IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnance					23d. Date of	f delivery
	death e atte d for	Icla	in the past 12 months?	1□Live birth 2□Fetal d 4□Pregnant at time of dea		ctopic pregnancy Other <i>(specify)</i>			Month	Day Year
P.0	t the by the tache	hys	9 🗆 Unknown	9□ Unknown						
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by Physician/M	Part II. Other significant conditions cor		ing in the und	lerlying cause give	n in Part I.	23e. Did tot	oacco use contribu	te to the cause of death?
ord	equir sen si lould	ted	ALZHEIMER'S DEMEN	<u> FIA</u>				1 ☐ Ye	es 2 🗆 No 3 🗀	Probably 4 MUnknown
ec	2 2 2	Completed						24a. Was a autops	v prior	e autopsy findings available to completion of cause of
<u>=</u>	: The	Con						perform	ned? deat	h? Yes 2□ No
Vit.	iicien: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?	lospital:		Otho	26. Place of Death			
o	Phys r this ral dii	. To	1 Yes 2 XNo	I □ Inpatient 2 □ E	R/Outpatient 8b. Time of	3 DOA	Nursing Hor		ence 6 Other (Specify)
on	ding th. : Afte fune	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 2	Injury	28c. Injury Work' M 1 7	? 'es 2 □ No	log. Describe no	w injury occurred	
Division of Vital Records,	Atter r dea ector by the	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At hom	e, farm, stree			28f. Location (St	reet and Number o	r Rural Route Number,
Ö	el or s afte of in t	Certification:	4 Homicide determined	building, etc. (Specify)				City or Towr	, State)	
	ospit hour unere ly fille		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge.	edge, death o	occurred at the time	e, date and place, a	and due to the ca	use(s) and manne	r as stated.
	To the Hospitel or Attending Physicien: The within 24 Hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)	ner: On the basis of examinatio and manner stated.	and/or inve					
	Viith To	2	29b. Signature and title of certifier	((. 0.		29c. License	number	2:	3d. Date signed (M	fonth, Day, Year)
			arolina	6. Centar		D15628	3		11/10/0	4
	8		30. Name and address of person who co			·				1
	Sta	te	CAROLINA C. CUSTOD] 31. Date filed (Month, Day, Year)	O, M.D., VA MA 32. Registrar's Signatur	ARYLANI re) HEALTH	CARE SYS	rem, per	RY POINT	, MD 21902
94	Registr		NOV 1 9 2004	b) war	4	land.				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0014 35724 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Marie Budrecki 08:43 AM au October 4000 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Morcy M

5. Social Security Number Medical Center Baltimore Baltmore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 F 213-05-1166 86 Director Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event. The Medical Examiner must be notified at Director MI ALTIMORE Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? ŏ 5. A or Items 23a 2122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after v dealth and Mental Hygiene. 9m 27 Is marked other than "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) KER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Town, State, Zip Code) 2(224 19b. Mailing Address (Str and Number or Jural Route Number, City or Department of Health a Importent: If item 27 is eny injury or other tra 20b. Place of Disposition (N. cemetery, crematory or 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Oonation 5 Other (Specify) 21. Ignature Funeral Service Licensee 23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Joseph Strategy that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) 4☐ Pregnant at time of death P.O. | 9□ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by page 2 should obstructive 1 ☐ Yes 2 ☐ No primonary 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed res 257 1 ☐ Yes 1 🗌 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death
1 Natural
2 Accident ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P18585 MO. October 26, 2004 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Street. Baltmore MD Goiscak m.D. Jason 21202 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 2 2004 Registrar

			1 - State		partment of Health and Certificate of Death		6004 35775
			Registrar 1. Decedent's Name (First, Middle, Last)		Crimoate of Death	Reg.	No. 3. Time of Death
п	Physici		HELEN		BUDRESKI		Day Year
7	/Medic Examir		4a. Facility Name (If not institution, give s	reef and number)	4b. City, Town, or Location of Dea		30 2004 20:04 ^M
			The Johns 7	topkins Hospita	1 BAltimor		NA
	Funeral Director		5.ISocial Security Number 6. Sex 248-09-2792	M 2) F 84 Yrs	Months Dave Hours Mir	(Month Day Yo	9. Birthplace (State or Foreign Country)
	yland now		10a. State 10b. County	10c. City, Town or	r Location		10d. Inside City Limits
	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Items 23a or 28a-1 show event, the Medical Examinar must be notified at	ctor	MD. NA	BALI	MORE		1 Yes 2 No
	ith th	Director	10e. Street and Number	1 /	10f. Zip Code	10g.	Citizen of What Country?
	s 23e		20/80 DON	SELL ST.	11224		U.5 H.
"	fter d	Funeral	11. Marital Status 1 1 □ Never Married 2 □ Married	Armed Forces2	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	specify Yes of No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
936	ours a	by	3/1 Widowed 4 □ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes No Specify:		Specify: 12 14: TE
21215-0036	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	completed) (G	ecedent's Usual Occupation ive kind of work done during most of w	orkina 16b.	Kind of Business/Industry
121	within iene. then "	mpi	Elementary/Second ry (0-12)	College (1-4or 5+)	e. DO NOT use retired)		1/1/2
	filed v Hygie other i		17. Father's Name (First, Middle, Last)	1	MEMANER 18 Mother's Na	me (First, Middle, Maid	en Sumama)
Maryland	Mental Mental arked o	o Be	FIBRUAN	KIELIAN	MAD	VST	= 1 120
ary	2 should and Men is marke sumatic	-	←0a. Informant's Name/R tionship (Typ	11/1/	ailing Address (Street and Number or F	ral Route Number Ca	or Town, State, Zip Code)
_	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		DONALD BUI	DRESKI 28	180 DOWNELL	51 DA	4. TO, MD. 24224
Baltimore	ges 1 it of He if Item or oth	-	20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Re		sposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
Ë	Pa Tier ury		`4 □ Donation 5 □ Other (Specify)	U. J. J	TANISLAUS	4-04 34	470 - MD.
Ball	permit. Pa Departmen Important: any injury once.		21. Signature of Peral Service License	10.00	22. Name and Address of Facility	HID. M1.2	1224
	#D3 4 0		220 Part Enter the disease or form	. special	SSST HUDSOL	51.0	NARDIA FA.
			23a. Part1. Enter the disease, or complete shock, or heart failure. List del one immediate Cause (Final			ic or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	c Shock		2 days
	Examiner			Due to (or as a consequent of):	1 Hypeardial In	Custon	21
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	Typicaraiar in	Parction	Jonays.
/	xecuted and I-transit	Examiner	that initiated events				
Ö,	be executed icien and burial-transit		resulting in death) Last	Due to (or as a consequence of):			
8760,	cate ohys the	dicai	d.				
9	=	/Me	IF FEMALE:	c. If yes, outcome of pregnancy			
Box	atte for	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death :	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	that the deed by the detached	Physician/Me	1	9 Unknown	o a other (specify)		
<u>α</u>	requires that the een signed by th hould be detache	by PI	Part II. Other significent conditions cont	ibuting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	v require been sig should b					1 ☐ Yes	2 No 3 Probably 4 □Unknown
9	aw Is b	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	Thate Th	Con				performed?	death?
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	anutal:		ath Check on one)	
of	Phys this al dii	. To	1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpat 28a. Date of Injury 28b. Time		Home 5 Residence	
	ding h. After funer	tion	1 Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how inj	ury occurred
Division	Attending r death. sctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,		28f. Location (Street a	and Number or Rural Route Number.
á	s afte	Certification;	4 Homicide	building, etc. (Specify)		City or Town, Sta	te)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical ((Check only 2 Medical Examini	zien: To the best of my knowledge, de	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated.
	thin 2 the 1 the 1 mplet	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		
	E 2 E 3		1/17	7			ate signed (Month, Day, Year)
		1	30. Name and address of person who con	pleted cause of death (Item 23a) (Tur	KED - O(JU JUCK	ober 30, 2004 more HD 21287
	V		CHRISTINE TOMPKINS	Johns Hopkins Hospita	1 600 North Walle	Street R. 11	mare HD 217.87
	Sta		31. Date filed (Month, Day, Year)	33. Registrar's Signature	Sports	par par	
	Registr	ar	NOV 1 2 2004	De enter D	sporter		

BROOKS, MARY K.

12:20 A.M.

2004

NOVEMBER 4,

			1 - For Stete Registrar	State of	Maryland / Depa Ce	artment of H	lealth and Death	Mental Hyg	giene 0 C	14	35726
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea	ıth		3. Time of Death
	Physici /Media		MARY KATHE	RINE BRO	OOKS			NOV.	04 200	Year) 4	12:20a M
	Examir		4a. Facility Name (If not institution	•	per)	4b. City, Town, c	or Location of Deat	th	4c. County		
			STELLA MARI	S		TIMON	IUM		BALT	ГІМО	RE
	Funeral Director		5. Social Security Number 218-46-3239	6. Sex 7.	Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birth Cou MAR	place (State or Foreign ntry) YLAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1	10d. Inside City Limits
	Aaryl Fsho	ō		IMORE	TIMON						1 ☐ Yes 2 X No
	28a-	Director	10e, Street and Number		111011	10f. Zip Code		1	log. Citizen of V	Mhat Cau	
	with 3e or	0	2300 DULANEY	VALLEY F	αS	2109	3	'	USA	Vilat Cou	11 u y :
	death ms 2;	Funerai	11. Marital Status	12. Was Deced				Specify Yes or No-		e - Ameri	can Indian,
980	d within 72 hours after death with the Maryland Jiene. I then "neturel", or Items 23e or 28a-f show The Medical Evaninet must be rodified at	by Fur	1 XNever Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Yes 2 If Yes, Give Year or Date	⊠ No	f Yes, specify Cuba 1 ☐ Yes 2 📉 No	an, Mexican, Puer Specity:	Specify Yes or No- to Rican, etc.)		ck, White,	etc.
Õ	72 ho	ted	15. Deceden	t's Education	16a. Dece	dent's Usual Occup	pation	4:-	16b. Kind of Bu		
21215-0036	d within 7 giene. ir then "r the Med	Completed	(Specify only highest Elementary/Secondary (0-12) 12YRS	College (1-4	or 5+)	kind of work done DO NOT use retired IGNER	during most of wo d)	rking	FLORI	ST	
pu	be filed ntal Hygie od other event, u	Be C	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle,	Maiden Sumam	10)	
yla	2 should be and Mental Is marked o	Tof	RICHARD L.	BROOKS			MARG	ARET KE	NNEDY		
Maryland	s 1 and 2 should f Health and Mer item 27 ls marke other traumatic		19a. Informant's Name/Relations					ural Route Number			
di.	s 1 and 2 of Health item 27 l		MARY E. BONA 20a. Method of Disposition	ARRIGO(NI	20b. Place of Dispo		DESON KI	Date KEYMA	AR, MD.		
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 Burial 2 Cremation 4 Donation 5 Other (S		comotoni oroz	natory or other plac	11/0	06/2004			
Bal	permit Depar Impor any in once.		21. Signature of Funeral Service	Licensee	22 I	Name and Addre	. JENKI	NS & SO	NS CO.	111	1 .
			23a. Part1. Enter the disease, or shock, or heart failure. List			er the mode of dyin	ng, such as cardia	or respiratory arm	est.		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	<	5245-4135	-31	1/21/63	e 60 MJ	ಎ		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):						
	ZAGIIIIIOI	70	Sequentially list conditions,	b	as a son suguence off;						
11	nsit	Examiner	di any, leading to immediate cause. Enter Underlying Cause (Disease or injury	340 10 131	at a concoquone ory.						
<u>,</u>	execu n and ial-tra	Exal	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					-	
8760,	ficate be executed physician and s the burial-transit	dical		d							
9	tificat ng phy as th	- ου ⊕									
.O. Box	that the death certifi ed by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive	ery Day Year
ds, P	es gu	by	Part II. Other significant condition	ins contributing to deat	h but not resulting in the u	nderlying cause giv	en in Part I.			ibute to th	ne cause of death?
Ö	w requir been si should	etec	1/2/2/250	2 262151	W. E.						
Il Records,	The law cate has page 2	Completed	distore	love g	Spirer.			24a. Was ai autops perform 1 Yes 2	y ned? d	rior to cor eath?	psy findings available inpletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					th (Check only on	9)		
of	S S S	မှ	1 Yes 2 No		atient 2 ER/Outpatien		4) Aursing H	ome 5 Reside	nce 6 Othe	r (Specify	<i>'</i>)
	ding Ph h. After thi funeral	lon	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	9	njury 28b. Time of Day Year) Injury	28c. Injun Worl	k?	28d. Describe ho	w injury occurre	∍d	
isio	Attending ir death. ector: After by the fune	icat	2 Accident investig 3 Suicide 6 Could n	not be ge Dless of	Injury. At home form the		Yes 2 □No	201 1			
Division	il or Attendater deatl	Certification:	4 Homicide determine	ined 289. Place of building,	Injury - At home, farm, stre , etc. <i>(Specify)</i>	эөт, тастогу, оптсө		28f. Location (Str City or Town		er or Hura	I Houte Number,
	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifyin 2 Medical I	g Physicien: To the be Exeminer: On the basi and manner	est of my knowledge, death s of examination and/or inv	occurred at the time restigation, in my of	ne, date and place pinion, death occu	, and due to the ca	use(s) and mar ate and place, a	ner as st	ated. the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	lods 1	20	29c. License	number	/ 29	9d. Date signed		
	4		30. Name and address of person v				DOAD 3	UTMONT TYPE	1/2 0		
	Sta	ta.	31. Date filed (Month, Day, Year)		2300 DULANEY	VALLEY I	AUAD 1	TIMONIUM_	MD 21	.093	
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1			1 - For State Registrer		Maryland		artment of rtificate of			ental Hy	giene Reg. No. 2	004	3572
	hysici /Medic		1. Decedent's Name (First, Middle GAIL		ROCKINGT	ON				2. Date of Do Month Vovemb	Day	Year 2004	3. Time of Death
1	xamin		4a. Facility Name (If not institution 1819 East Balts				4b. City, Town, Baltimo			**************************************		nty of Death	
	neral ector		5. Social Security Number 214-54-5920		Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	r If Unde	Min.	B. Date of Bi (Month, Di 02-16-	1952	9. Birth Co	hplace (State or Foreig untry) MD
laryland	Show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, T								10d. Inside City Limits
ith the M	e notifie	Director	MD 10e. Street and Number	N /A	BAL	TIMOF	RE 10f. Zip Code	· · · · ·			10g. Citizen	of What Co	1√ Yes 2 No untry?
ath w	Time and the second	rai	1819 E. BALTIN				2123	31				USA _	
5-0036 72 hours after death with the Maryland	ai, or nems 23a or 20a-1 snov Exertirer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorced		ese? ∰No	- 1	Was Decedent of If Yes, specify Cut 1☐ Yes -2☐,No	ban, Mexica	an, Puerto Ri	fy Yes or No can, etc.))- 14. F		
_ c *		Completed	15. Deceden (Specify only highe	it's Education st grade completed)	1	6a. Dece	dent's Usual Occu kind of work done DO NOT use retire	ipation	st of working	1	16b. Kind of		
	event, the Medical	Be Com	Elementary/Secondary (0-12) 17. Father's Name (First, Middle,		for 5+)		SUPERVIS		ner's Name (First, Middle	CENSU Maiden Sum		EAU
should be not Mental		To B	JULIUS BROO	CKINGTON					NII	RA AL	EXANDE:	R	
Mar nd 2 shu lith and	other treumatic		19a. Informant's Name/Relations NEALETTE COOPER				ng Address (Stree SARGEAN						ip Code)
0 8 0	= =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate ceme	of Dispo	sition (Name of natory or other pla	ice)	Dat 11/13/	6	20c. Locatio	n - City or T	Fown, State
Baltim permit. Pag Department	eny injury o	j	21 Signature of Funeral Service			22	2. Name and Addr	ess of Facil	ity JAMES	S A. M	ORTON	& SONS	S F.H., INC
be executed was a maxement of the second of	priner transit	edicai Examiner	23a. farty Enter the disease, or speck, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to inhibediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hype to (or b. Oue to (or c.	in line.	ce of):	er the mode of dyi					ler	Approximate Interval Between Onset and Death
death certif	or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ★Unknown		n 2 ☐ Fetal dea it at time of death		Ectopic pregnanc	у				Date of deliv Month	very Day Year
ords, r.O. requires that the		ρχ	Part II. Other significant condition	ons contributing to deal	h but not resultin	g in the ur	nderlying cause giv	ven in Part I	l.		obacco use co		the cause of death?
The law	30 2	Completed								24a. Was autop perfo 1 □ Yes		prior to co death?	opsy findings available ompletion of cause of 2 \(\square\) No
99	Irector,	o Be	25. Was case referred to medical examiner? 1 □ No	Hospital:	-1:		Ott		e of Death (C			-	-
ding After	funeral	\vdash	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	9		Outpatien Time of Injury	28c. Injur	ry at	280		lence 6 XO		y) scene
Hospital or Attending 24 hours after death. Funeral Director: After	d in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of	Injury - At home, etc. (Specify)	farm, stre	eet, factory, office		28f	Location (S City or Tox	itreet and Num n, State)	iber or Run	al Route Number,
le Hospital or 24 hours after 10 Funeral Dire	ely fii	edical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be Exeminer: On the basi and manner	s of examination	lge, death and/or inv	occurred at the tir restigation, in my o	me, date an opinion, dea	nd place, and ath occurred	due to the a	cause(s) and nate and place	nanner as s , and due t	stated. o the cause(s)
To the I	comp		29b. Signature and title of certifier Zalui		Le.		29c. Licens				29d. Date sign		
	2		30. Name and address of person	who completed cause of							Novem	ber 1	0, 2004
	Stat	te	31. Date filed (Month, Day, Year) NOV 12	2004 Per	n Stree istrar's Signature	t, B	altimore,	, Mary	land	21201			
Re	egistra	O1	1101 1	LUU4 CALL		19							

State of Maryland / Department of Health and Mental Hygiene 2001

			1 - State Registrar	01410 01 111	a. y tarra /	Cer	tificate of	Death	ic Mental 11	Reg. N		14	35/2	8
	Physici	an	1. Decedent's Name (First, Middle, L	ast)	-			· · ·	2. Date of D	Death			3. Time of Death	
	/Medi			unins					NOVEM		8, 200	ar 4	5:10P.	М
	Examir	ner	4a. Facility Name (If not institution, g	ve street and number)			4b. City, Town, o	or Location of D	Death	4	c. County of I	Death		
-			619 WATERWHEEL 5. Social Security Number 6.	ANE Aparti	ment 22		MILLER		U T		NNE AR			
	Funeral Director		388-34-6972 Usual Residence of Decedent	Sex 7. Ag 1QXM 2□F	ge (In yrs. last I	Yrs.	If Under 1 Year Months Days		Min. 8. Date of E (Month, I Feb. (orth Day Yea 06 1	937	Birthpla Countr La	ce (State or Forei y) tiva	дn
	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation					10	d. Inside City Limit	S
	Man B-1 st	tor	Maryland Anne A	rundel			Mill	lersvil	1e				1 ☐ Yes 2 ☐XN	0
	th the or 28)ire	10e. Street and Number				10f. Zip Code			10g. C	Citizen of Wha	t Countr	y?	_
	eth w	rai	619 Waterwheel L	ane Apt. 2	.2			21108			US	iΑ		
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-1 show event, the Madical Expriner must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cub ☐ Yes 2 X No		? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - / Black, V Specify:		c.	
5-("natu	etec	15. Decedent's I (Specify only highest g.		16	a. Deced (Give	ent's Usual Occup kind of work done OO NOT use retire	pation during most of	working	16b.	Kind of Busin	ess/Indu	stry	
121	within lene. than he Ms	Completed	Elementary/Secondary (0-12)	College (1-4or	O+)		<i>ronic</i> En		,	Dv	oioct I	Mana	aon	
d 2	filed Hygie ther		12 17. Father's Name (First, Middle, Las	5+		Tect	TOTAL ET		Name (First, Middl		oject	'lalla	ger	
lan		To Be	Janis Brur					Vand			n oumame,			
ary	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship		19	b. Mailin	g Address (Street		r Rural Route Num		or Town, Sta	e, Zip C	'ode)	_
Σ	is 1 and 2 should of Health and Mer Item 27 is marke other traumatic								Hansvil ¹					
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	20b, Place	of Dispos	sition (Name of atory or other place		Date		Location - City			_
Ě	Pages ment of I ant: If It		4 □ Donation 5 □ Other (Spec	28			ematory I	Inc No	ov. 09 2004	Bal	timore	, Ma	aryland	
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Feneral Surviva Library	ntee /			Name and Addre	ss of Facility	Stall pad, Pasa				lome, P.A	١.
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that caused one cause on each li	the death. Do	not ente	r the mode of dyin	ng, such as car	diac or respiratory	arrest,		lr lr	pproximate nterval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. INTTO	etal or	175	not wo	ind				C	Inset and Death	
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	certificate be executed Iding physicien and Ise as the burial-transit	Medicai	IF FEMALE:											
.O. Box	that the death certific ed by the attending pl detached for use as t	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Da	ay Year	
Ω.,	The law requires that ate has been signed b bage 2 should be deta	by Pr	Part II. Other significant conditions	contributing to death b	ut not resulting	in the un	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute	e to the	cause of death?	
Records,	quire; nn sìgi uld be	q pa				_			10	Yes 2	1 № 3 □	Probab	ly 4 ∐Unknowr	1
000	law requir as been si 2 should	Completed							24a. Was	an	24b. Were	autopsy	findings available	
	The lav	HO								ormed?	prior death	to comp	letion of cause of	
Vital	yeiclan: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?					26. Place of I	Death (Check only	2□No one)	1 [X]	95 21	□ No	_
	dis dis	٩	1X Yes 2 No		nt 2□ER/O			4 Li Nursin	g Home 5 Res	dence	6 Other (S	pecify S (CENE	
n c	ing P	iuo:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da)	28b.	Time of	28c. Injury Work	y at k?	28d. Describe	how inju	ry occurred		15	7
Sic	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 □ Could not be	1- 0-0		5:07	1	Yes 2 No	Sub	ect	Shot	2.6	17	
Division of	after Direction by	Certification;	4 ☐ Homicide determined	28e. Place of Inju- building, etc	c. (Specify)	arm, stre	et, factory, office		28f. Location (Street ar	nd Number or	Rural R	oute Number,	C
	Hospital or Attending 24 hours after death. Funeral Director: After etely filled in by the funer		29a. Certifier 1 ☐ Certifying Pl	ysician: To the best of	of my knowledg	e death	nocurred at the tim	ne date and pl	and due to the		ille,	14	1)	_
	To the Hospital or Attending Prwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only a Medical Example)	niner: On the basis of and manner sta	examination at	nd/or inve	estigation, in my op	oinion, death o	ccurred at the time,	date an	d place, and d	ue to th	od. 9 cause(s)	
	To the within 2. To the complet	M	29b. Signature and title of certifier	000)		29c. License	number		29d. Da	ite signed (Mo	nth, Day	v, Year)	
•			Jan ()	tolk	ch.	<i>></i>	0.C.	M.E.		NOVE	MBER 9	. 20	004	
1	F		30. Name and address of person who	completed cause of de		(Туре, Р	rint)							_
10	,			J. CA- [3]	AK MF	> 1	11 Penn	Street	, Baltimo	re,	Maryla	nd 2	21201	
	Stat Registra		31. Date filed (Month, Day Year) 20	04 32. Flegistra	r's Signature	9	South	,						

Registrar

			1 - For State Registrar	State of Maryl	_	artment of H rtificate of L			ene 2001	35729
			1. Decedent's Name (First, Middle, Last,)				2. Date of Death Month		3. Time of Death
	Physici /Medic	al	WINIFRED WATS 4a. Facility Name (If not institution, give		Γ	4b. City, Town, or	Location of Death	November		
	Examin	ier	225 Gaywood Roa				imore	'	1	ltimore
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In)	vrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign Country)
	Director		207-18-4481	[™] XX ^F 86	Yrs.	Months Days	Hours Min.	June 14,	19 18 1	Pennsylvania
	pur &		Usuel Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	reation				10d. Inside City Limits
	Aaryli Fsho	ō			•					1 Tyes 2 No
	the A	Director	Maryland Baltimor 10e. Street and Number	<u>'e</u>	Baltimo	10f. Zip Code		10.	g. Cîtîzen of Wha	
	3a or		225 Gaywood Road			2121	2		USA	a obtain.
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-		American Indian,
21215-0036	72 hours after death with the Maryland inetural, or Itams 23e or 28e-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4XX0ivorced	1XX es 2 □ No If Yes, Give Year or Dates:	I LIWN	1 ☐ Yes 2 X XNo	Specify:	o nican, etc.)	Specify:	White, etc. White
9-10	72 hou	ted	15. Decedent's Edu	ication		dent's Usual Occupa		tina 10	6b. Kind of Busin	ess/Industry
21	⊆ 3	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done o DO NOT use retired))	king		
7		Con		4	Hom	emaker			Own 1	Home
Maryland	o to to	To Be	17. Father's Name (First, Middle, Last) Wilford Ivor Jack	Watson				ne (First, Middle, Mi e Hermine		ı
ary	s 1 and 2 should f Health and Men itam 27 is marke other traumatic.		19a. Informant's Name/Relationship (Ty					ral Route Number,		
	l and 2 lealth im 27 i		Marjorie W Bookhou			-	load Balt	imore, Ma	ryland 2	21212
Baltimore,	ges 1 ar t of Hea lf itam or othe		20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ F	Removal from State		natory or other place			Oc. Location - City	
ij	tmen tmen tant:		'A Donation 5 Other (Specify)	Gi	The second second second	nt Cemete				e, Maryland
Bal	permit, Pages Department of F Important: If ite any injury or of		21 Ignature of Funeral Service Licen	Cnaker		. Name and Addres	6500 Yor	k Road Balt	imore, Mar	eral Home Inc ryland 21212
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the d ne cause on each line.	leath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a col	Failur	Hypoxo	emia			Oliset and Death
	Examiner			Due to (or as a con-	sequence of):	DI -	b			
	-	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cond	endanumen ni):	Pulmoney	Viscot		-	
	uted d ansit	Examin	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
o,	an an irial-tr	Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	cate be executed physician and the burial-transit	dical		d.						47411
Φ	entific ding p	Med	IF FEMALE:	23c. If yes, outcome of pre						
Вох	death certifi e attending I id for use as	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
o.	0 00	nysk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	ordeath 5	Other (specify)				
S, P	g g g	by Pr	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribut	te to the cause of death?
rds	w requires been signe should be							1 Yes	2 □ No 3 □	Probably 4 Unknown
Vital Record	e law requ has been je 2 shoul	ompleted						24a. Was an	24b. Were	autopsy findings available
Ä		Com						autopsy performe	id? deat	to completion of cause of h? Yes 2□ No
/ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					th (Check only one)		
of	this al dii	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2						Specify) Home Horrica
uo	ding After fune	lon	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Work	at ? /es 2 □ No	28d. Describe how	injury occurred	
Division	deal deal	fica	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, str		2 110	28f. Location (Stre	et and Number o	r Rural Route Number,
Ö	s after s after al Dire ed in b	Certification;	4 Homicide determined	building, etc. (Spe	ecify)	,,		City or Town,	State)	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or in	occurred at the tim restigation, in my op	e, date and place, inion, death occur	and due to the cau red at the time, date	se(s) and manne and place, and	r as stated. due to the cause(s)
	To th: withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	290	I. Date signed (M	onth, Day, Year)
	-/		1021 MM	- WD		D414	76	11	. 10,20	04
	18		30. Name and address of person who co	ompleted cause of death (I	Item 23a) (Type, N, CHARU	Print)	16 HIG, BA	ETIMORE	MD 212	34
	Sta		31. Date filed (Month, Pay 2 ear)	32. Registrar's Si		Sports				
	Registr	ar	. 10 1 - 10 2001	1	/- /	-Joseph -				

			1 - For State of N		partment of Health and Mertificate of Death	Mental Hygie		35730	
	Physici /Medi		Decedent's Name (First, Middle, Last) MURIEL ELY BUDDEN	MEIER		2. Date of Death Month November	Day 2004	3. Time of Death 8:30P M	
	Examir		4a. Facility Name (If not institution, give street and number Presbyterian Home Of Mary)	land	4b. City, Town, or Location of Death		4c. County of Death Baltimo	1	
5	Funeral Director		404 605	Age (In yrs. last birthday Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye February 10,	ar) 9. Birth Cou 1915 MAry	place (State or Foreign ntry) land	
	e Maryland Sa-f show	ctor	10a. State 10b. County Maryland Baltimore	10c. City, Town or L	ocation			1 Yes 2 No	
	th with th 23a or 20 ust be no	Funeral Director	10e. Street and Number 400 Georgia Court		10f. Zip Code 21204	10g.	Citizen of What Coul		
036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "naturel", or items 23s or 28e-f show after other than "naturel", or items 25s or 28e-f show afte avent, the Medical Examinat must be natified at	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Y Wildowed 4 Divorced 12. Was Deceder Armed Force; 1 Yes 2 Wes Year or Dates	N/O	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XX No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whij	etc.	
Maryland 21215-0036	d within 72 ho plene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o	r 5+) (Give	adent's Usual Occupation e kind of work done during most of work DO NOT use retired) ECPETARY	ing 16b.	Kind of Business/in	dustry re Count.y	
yland ;	should be filed and Mental Hyg marked othe umatic avent,	To Be C	17. Father's Name (First, Middle, Last) Frank Emerson Ely		18. Mother's Name	e (First, Middle, Maid l Melcher		Te dountry	
	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) Richard E Buddemeier	Son 754	ing Address <i>(Street and Number or Rur.</i> Roslyn Avenue Glen	al Route Number, City Side Penns	y or Town, State, Zip Sylvania 1	Code) 9038	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or items 23s or 28a-f show any injury or other traumatic avent, the Mudical Examiner must be notified at ORCe.		20a. Method of Disposition 1 ★ Gurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 2 Signature of Funeral Sprvice Licensee	Parkwood	Cemetery 11/10 2. Name and Address of Facility Mitc	/04 Ba chell-Wiedefe	Location - City or To Itimore, eld Funeral	Maryland Home Inc.	
	Physician /Medical Examiner			is a consequence of):	6500 York Iter the mode of dying, such as cardiac of	Road Balting or respiratory arrest,	ore, Marylan	d 21212. Approximate Interval Between Onsel and Death	
58760,	death certificate be executed e attending physician and of for use as the burral-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):					
O. Box	at the death certific by the attending p tached for use as	Physician/Me		2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>		23d. Date of delive Month	ry Day Year	
rds, P	The law requires that the ite has been signed by thoage 2 should be detached.	ed by P	Parvil. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given in Part I.		use contribute to th	e cause of death?	
		e Completed by	fillymyplyu Ihleun 25. Was case referred to medical	ralica		24a. Was an autopsy performed?	prior to con death?	ssy findings available apletion of cause of	
<u></u>	× ≤ 5	To B	examiner?		- Taroling Hol	ne 5 🗆 Residence)	
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the tuneral	ertification;	1 DNatural 5 Pending (Month, D) 2 Accident investigation 3 Suicide 6 Could not be	ay Year) Injury njury - At home, farm, str	Work? M 1 □ Yes 2 □ No	28f. Location (Street a	how injury occurred		
	sepital or A hours after ineral Direc y filled in by	O	29a. Certifying Physician: To the best	t of my knowledge, death	D OCCURRED at the time, date and place	City or Town, Sta	(e)		
	To the Hospital of within 24 hours af To the Funeral Discompletely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis and manner s 29b. Signature and title of certifier	oi examination and/or in	29c. License number	ed at the time, date ar	ate signed (Month, D	the cause(s)	
1	V		30. Name and address of person who complete cause of	death (Item 23a) (Type.	Print) CHARLES ST	Nov	05,20	04	
- 50	Stat		MATUNO COM	rar's Signature	V CHARLES ST	SALTIM	ore M	0 21204	

DHMH 17 Rev 1/200:

ORIGINAL

			1 - Stete Registrer	State of Mar	yland / Depa <i>Cer</i>	artment of I	lealth and Death	Mental Hyg	iene 20	04 35731		
	Physici /Medic		Decedent's Name (First, Middle, Last H/	RVEY	EDWIN	BASI	Κ	2. Date of Dea		3. Time of Death 7:20 Р м		
	Examir		4a. Facility Name (If not institution, give 3400 LABYRINTH I			4b. City, Town, o	Dr Location of Dea	ath	4c. County of			
	Funeral Director		5. Social Security Number 217-20-1423 Usual Residence of Decedent	ex M 2□ F 7. Age (I	n yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		1926	9. Birthplace (State or Foreign Country) NY		
	Maryland f show	or	10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No		
	with the la or 28a-	Director	10e. Street and Number 3400 LABYRINTH I		57.21	10f. Zip Code	21215	1	0g. Citizen of Wh			
036	d within 72 hours after death with the Maryland piene. rr than "natural", or Items 23a or 28a-f show The Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ∭Yes 2 ☐ No If Yes, Give Year or Dates:	11	Vas Decedent of H Yes, specify Cub		Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.		
21215-0036	d within 72 piene. r than "nai	Completed			(Give life. L	ent's Usual Occup kind of work done DO NOT use retire MACIST	during most of w	orking	16b. Kind of Busi	,		
Maryland	should be filed and Mental Hygis marked other umatic event, II	To Be	17. Father's Name (First, Middle, Last) JULES		BASI		MOLL	Mother's Name (First, Middle, Maiden Surname) MOLLIE LEVY				
	is 1 and 2 should be filled of Health and Mental Hyg item 27 Is marked othe other traumatic event,		19a. Informant's Name/Relationship (1888) BARBARA BASIK / W	IFE	3400	LABYRIN		BALTIMO	-			
altimore,	permit. Pages 1 Department of H Important: If ite any injury or otl		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specify	Removal from State	sition (Name of patory or other place EL CEMETE	· 1	Date 10/2004	20c. Location - Ci BALT	ty or Town, State			
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licen	500				OL LEVINS ROAD - P		S., INC. E, MD 21208		
. 1	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	atic Lur	_		ac or respiratory arre	est,	Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a co		d				6 Monta		
8760,	icate be executed physician and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co								
.O. Box 687	death certif e attending id for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	∃Fetal death 3 □	Ectopic pregnancy Other (specify)	1		23d. Date of Month			
Δ.	Se un eq	by	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the un	derlying cause giv	en in Part I.		`	ute to the cause of death?		
Vital Records,	10	Completed	U					24a. Was ar autopsy perform 1 Yes 2	prio dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No		
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes Yes	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	3□ DOA Oth		ath (Check only one		(Specify)		
ion of	Attending Phyric death. sctor: After thing the funeral of the fune		27. Manner of eath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injur Wor M 1 🗆	y at	28d. Describe hor		Creenly)		
Division	tal or Attencts after death all Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number (State)	or Rural Route Number,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Example 1	vsicien: To the best of m iner: On the basis of exa and manner stated	amination and/or inve	occurred at the tin estigation, in my o	ne, date and plac pinion, death occ	e, and due to the caurred at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)		
)	with To t	Σ	29b. Signature and title of certifier Kennyy	elemo.		29c. Licenson	number 67 2			Month, Day, Year)		
	10		30. Name and address of person who de Kenneth L. Gli	ompleted cause of death	(Item 23a) (Type, P	rint) ullamore	Rd Lu	therville 1	MD 210	93		
	Sta Registr		NOTE IN TOUR AND A COMPLETE AND A CO									

State of Maryland / Department of Health and Mental Hygien200135732 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** William Gwyn Brown A^{M} 1100 November 8, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Months Days Hours 82 212-28-6894 19, 1922 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1 Yes 2 No Maryland Harford Aberdeen Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1123 Carsins Run Road 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White φ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Repairman Farm Machinery 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) James Emory Brown Eula Elizabeth Marsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1123 Carsins Run Road, Aberdeen, MD M. Janelle Brown/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem.Gardens 11-12-2004 Bel Air, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAIWRE Proyection /Medical Due to (or as a consequence of) Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PAROXYSMAL ATRIAL FIBRILLATION death certificate be executed use as the burial-transit the attending physician Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTENSION 1 Yes 2 No 3 Probably 4 Unknown been FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has OBSTRUCTIVE PULMONARY DISEASE CHRONIC 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral I

completely filled 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Andre Now-linds no NOVEMBER 8, 2004 D08096 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 125 N, MAIN ST. BELAIR, MDNOY HNAKEN NOWAKOWSKI 31. Date filed (Month, Day, Year) 32. Registrar's Signature Sporks

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 2 2004

ROWN

				For State Registrar	State	of Marylan	id / Depa <i>Cei</i>	artment of I tificate of	Health and <i>Death</i>	i Mental Hy	giene 0	04	35733
		Physici	an	Decedent's Name (First, Middle,						2. Date of De Month		Year	3. Time of Death
		/Media	cal	Francis 7 4a. Facility Name (If not institution,		Brandis,	Sr.	4h Chi Taua		Neven		2004	3:25 M
		Examir	ier	Upper Chesapeak			r	_	or Location of De . Air	atn	1	arfor	77
		Funeral			. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	rth		place (State or Foreign
		Director		180-24-8581	¥∆ M 2□ F	71	Yrs.	Months Days	Hours M	in. (Month, Di Apr. 3	1933	Penn	sylvania
		and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					Od. Inside City Limits
		Maryl 1 sho	for	Maryland Harfo	rd		elcamp						1 ☐ Yes 2 ☒ No
		death with the Maryland ms 23s or 28s-1 show rmust be notified at	Director	10e. Street and Number	<u> </u>		CICAMP	10f. Zip Code			10g. Citizen of	What Cour	itry?
		th wit	alD	4760 Water Par	k Drive	Unit B		210	17			USA	
		er dea tems	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U. forces?	.S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or Ne erto Rican, etc.)	o- 14. Rad Bla	ce - Americ	
P.W	36	irs afte	by F	1 ☐ Never Married ♣ Marrie 3 ☐ Widowed 4 ☐ Divorced	I Tes, G	2□No live Dates1951-	EE .	□Yes 2√1 No	Specify:		Specif		
	9	2 hou stura		15. Decedent's	Education		16a. Deced	lent's Usual Occu	pation		16b. Kind of B		<u>hite</u> _{dustry}
:25	215	thin 7 e. an "n Med	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	(Give life. I	kind of work done OO NOT use retire	during most of ward)	vorking			,
50	21	led wi			4		Distr	ibution :					acturer
140	and	i be fi	Be	17. Father's Name (First, Middle, La Francis (unk		Nic.				lame (First, Middle Bentle			
	Maryland 21215-0036	should nd Me mark imatic	2	19a. Informant's Name/Relationship		ALD	19b. Mailin	g Address (Street		Rural Route Numb			Code)
_	N N	alth a 27 ts er trad		Bernadette D. B	randis /	/ Wife							MD 21017
108/04	Baltimore,	of He of He representation		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3	□ Romoval from		lace of Dispo	sition (Name of natory or other pla		Date	20c. Location		
00	Ë	Pag ment tant: I		`4 ☐ Donation 5 ☐ Other (Spe	cify)		lltop :	Service (Corp. 11	-10-04	Towson	Mar	yland
=	Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 show any jointy or other traumetic event, the Wedical Examiner must be notified at one:		21. Sign to e of Fune a Service Li	- mge	_	22 Mc	Name and Addre	ess of Facility	Iome, P.A bad, Abin	_		A STATE OF THE STA
				23a. Part1. Enter the disease, or conshock, or heart failure. List or	mplications that ly one cause on	caused the death each line.	h. Do not ente	er the mode of dyi	ng, such as card	iac or respiratory a	rrest,		Approximate Interval Between
		Physician (Madies)		Immediate Cause (Final disease or condition resulting in death)	_a	Sept	Tic_	Shi	ock				Onset and Death
		/Medical Examiner		recoming in douin,	Due to	o (or as A d insequ	uence of):	1 . 0	1 / 1 =				131
			ler	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a cons-q	uence of):	4500	015	cus		_	1 > 1000
,	K	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	c.	a.c.men							
0	90,	cate be executed obysician and the burial-transit		resulting in death) Last	Due to	o (or as a consequ	uence of):						
3	8760	cate be physicia the bur	dlca		d							-	
52	9 x	leath certifica attending ph I for use as th	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregna	incy				22d Da	te of delive	n,
去	Box	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Iclar	in the past 12 months?	4☐Preg	birth 2□Fetal nant at time of de		Ectopic pregnanc Other (specify) _	У				Day Year
MP	P.0	uires that the de signed by the a id be detached f	Phys	9 🗆 Unknown	9∐ Unki					-			
		res thaigned	by	Part II. Other significant condition	contributing to	death but not resi	£		1				e cause of death?
\wedge	of Vital Records,	w requir	eted	12 12 VCEN	al Ita	1 Luze	_	actica	aciaos	>15		3 Proba	
4	Rec	has t	omplet	Hyper Ma	ques	emia	Ce	arebral	ANOX	24a. Was autop	psy	Were autop prior to com death?	osy findings available npletion of cause of
کے	la		e Co	25. Was case referred to medical	they				00 Pt4 P	1 ☐ Yes	2 2 No		2 No
3,	N N	Physician: this certificatal director, I	o B	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:	Inpatient 2	ER/Outpatien	3□ DOA Ott	100	eath (Check only only only only only only only only		er (Specify	·)
h+-		ding Ph I. After th funeral	Liuc	27. Manner of Death 1. ☑Natural 5 ☐ Pending	28a. Date	-	28b. Time of	28c. Inju	ry at		how injury occur		,
5	Siol	Attanding ir death. ector: After by the fune	catle	2 Accident investiga 3 Suicide 6 Could no	ion				Yes 2 □No				
Standie,	Division	l or Attandi after death. Director: A	ertiflcation;	4 Homicide determin	d 200. Plac	e of Injury - At ho ding, etc. (Specif)	ome, farm, stre	eet, factory, office		28f. Location (City or To	Street and Numb vn, State)	er or Rural	Route Number,
0	_	spital	O	29a. Certifier Certifying	Physician: To th	e best of my kno	wledge, death	occurred at the fi	me, date and ola	ce, and due to the	cause(s) and ma	nner as st	ated
0		To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Ex	aminer: On the l	basis of examination of the state of the sta	tion and/or inv	estigation, in my	pinion, death oc	curred at the time,	date and place,	and due to	the cause(s)
		To ti Vithi To ti comp	Ě	29b. Signature and title of certifier	0-1-			29c. Licens	se number		29d. Date signed		
	,	\mathcal{J}_{\cdot}		200	30	2		Do	05356	58 1	Jovembe	5 8	,2004
		1,5		30. Name and address of person when A Salar	-	ise of death (Item		rint) Upoc	clopso	aparter . Chesar	Medica	Rei	ntes
		Sta	te	31. Date filed (Month, Day, Year)		Registray's Signal		1 1391	Air, F	700 4 (00	Not 21	014	\
		Registr		NOV 1	2 2004	Benev	a /	s spo	res				

State of Maryland / Department of Health and Mental Hygien 2001 1 - For State Registrar 35734 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Thelma Carter 30, 8:02 PM M October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 Under 1 Year | 1 Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 Under 1 Year | 1 Under 1 Year | 1 Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🖾 F 79 1925 244-36-2679 Director South Carolina Usual Residence of Decedent 72 hours after deeth with the Maryland 10a. State 10b Counts 10c, City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Moderal Examinations to a chiling at MD Prince George's Forestville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7420 Marlboro Pike 20747 Funerai **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ρ If Yes, Give Year or Dates: black 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) unk unk seamstress clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carlise Carter Nora Shell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ts m any injury or other traum QDC6. 1303 Karen Blvd Capitol Heights, MD 20743 Dorothy Gray/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 6 NOther (Specify) in state 21. Signature of Funeral Service Licensee Ronald S Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD $21201\,$ /ac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONG-ESTWE HEART if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ERLOTIC CARDIOVASCILLAR DISCASE THERWSA use as the burial-tran resulting in death) Last Due to (or as a consequence of) the attending physician Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached is been signed by the should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1ABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown ENSIO 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has h page 2 certificate Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 2 No 1 Yes 1 Nnpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral I 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN 11-01-2004 D 52900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUSA MOMOHMO 8700 CENTRAL 4301, LANDOVER MD 20785 MOMOHMO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 2 2004

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Cherry State of Maryland / Department of Health and Mental Hygiens 04 - 71931- State Registrar AMEND ITEM #20a-c PER FH G837e1thibe24 03 DHEAth AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** November 6, 9:43 P M 2004 /Medical 4a. Facility Name (If not institution, give street and rumber) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number Date of Birth (Month, Day, Funeral 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Months Days Hours 1X M 2□ F 212-94-2958 Usual Residence of Decedent Yrs. Director the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event. The Medical Evantinar must be notified at 1 XYes 2 □ No Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5626 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or iten any injury or other traumatic event. The Medical Evantinations. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ohr 19a, Informant's Name/Relationship (Type, Pint) (SISTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Commation 3 ☐Removal from State * 4 □ Donation 5 □ Other (Specify) CREENMOUNT CREMATORY 11/15/04 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Joseph L. Rus Joseph L. Russ F 2222 W. North Ave Fuperal Balto. 1to, me 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heart tallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Gunshot WOUND /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner iding physician and se as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai as use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \sum No 24a. Was an 1 Yes 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 1 Inpatient 2 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 XXR/Outpatient 3 □ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural death. 1061 04 9:10 1 ☐ Yes 2 🕱 No 50b ect 2 Accident after death Shot 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 3 400 B / CC K 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide street E Preston St, But more City within 24 hours a To the Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 7, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Man) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Wenter 8 **Physician** 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore aryland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours Min. Days 218-78-294' Usual Residence of Decedent 1Å M 2□ F Director the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-fehow traumatic event, the Madical Examinar hunt be notified at 1 Yes 2 No Completed by Funeral Director Maryland mor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 or items 23a death O Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Nover 2 Nover Nover 1 Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☑ Divorced Year or Dates: "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic avent. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) | Brether 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 me Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State ⁴ ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Licenses 22. Name and Address of Facility Joseph 2222 Home RUS uneral 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death uber culosis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (ur as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? ş Division of Vital Records, page 2 should be Failure 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 20 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Yes this Date of Injury (Month, Day 27. Manner of Death 28a. 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) land m. O. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 2 2004 Registrar

PM 4 - 07277Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#7, perfff C837, 11/12/04 TT
State of Maryland / Department of Health and Mental Hygien 2004

Certificate of Death wight Chase 35737 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Day Vear **Physician** CHASE WIGHT ALL 2004 EL November 10. 18:55 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University Hospital Baltimore NIA If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1₽M 2□F 53 214-56-9831 Yrs. MARY MARCH AND **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show Examiner must be notified at 1 No 2 No Directo MARYLAND 28a-f 1bg. Citizen of What Country? 10e. Street and Number 6 NORTH USA 238 FULTON Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filad within 72 hours aftar 1 Never Married 2 ☐ Married ☐ Yes 2 X No 1 Yes 2 No Baltimore, Maryland 21215-0036 ö Specify: If Yes, Give Year or Dates: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) alth and Mantal Hygiena. 27 ia markad othar than ir traumatic evant, the Me other than College (1-4or 5+) AKER BAKERI 1 THGRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RLEAN WILKERSON ELLIOT1 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) AVENUE RISMER BALTO, MO. 212 Haalth am 27 i FRANCINE JOHNSON SISTER. Important: If item any injury or otha. itam 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of 21. Signature of Funeral Service Licensee Facility BROWN JR. FUNERAL HOME AVE., BALTO, MD 2121 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) omplie a **Physician** /Medical Due 10 (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Physician: The law requires that the death certificate be axecuted Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an page 2 s autopsy performed Sale 2 🗌 No certific Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 11 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) his 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Aftar Hospital or Attanding Injury 1 Natural 5 Pending investigation Deceased run ones 5:48 PM 1 ☐ Yes 2 No 6/6/04 2 Accident Diractor: / 6 Could not be 3 ☐ Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ZCOO BILL C determined Under Ane Balto, MD Street within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little

State Registrar

5 31. Date filed (Month, Day 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature Bener

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

November 11, 2004

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Physician John Anthony Cooney November 2004 11:30AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 5015 Middlesmoor Court Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □XM 2 □ F Yrs. Director 156 03 8013 Oct 31, 1922 New Jersey Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Depertment of Heelih and Mentel Hygiene.

Important: If Item 27 is merked other than "naturel", or Items 23e or 28e-f show any fulury or other traumatic event, the Medical Example, must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Delaware Drexel Hill 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 801 Concord Avenue 19026 United States Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 SYes 2 No If Yes, Give Year or Dates: WWII altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Š 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Physicist Research/University 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Anthony Cooney Ellyne Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Elizabeth Brunner/Daughter 5015 Middlesmoor Court Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. View Cemetery 11-12-2004 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) M0104422. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner ettending physician end for use es the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? effusion 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Altzheiners Dementia After this certificete has been 1 ☐ Yes 2 ☐ Xio 1 ☐ Yes 2 ☐ No or Attending Physician: funerel director, Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) daughter's Other: 4 Nursing Home 5 Residence 6 Other (Specify) home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 Yes 2 XNo 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending investigation efter death. Director: Aft 2 No 2 Accident 6 Could not be determined 3 🗆 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours ever To the Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated. Medical 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 11/10/04 022302 UW-30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Sandra Sattin, MD.

21043

State Registrar 2850 N

31. Dete filed (Month, Day, Year)

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2 2004

Ellicott City

ORIGINAL

32. Registrer's Signature

Amend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 0 4 1 - For State Registrar 35739 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year 24A C/2 255/in Kilhard Mismale? 200 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE RANDAUSTOWN MORTHWEST HUSPITAL 8. Date of Birth Month, Day, 0CT. 9, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 1 M 2□ F Months 219-18-7589 81 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🕅 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1602 WOODLING WAY 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No WWII If Yes, Give Year or Dates: ARMY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No WHITE Specify: 3 Widowed 4 Divorced ARMY 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 PROPRIETOR PICTURE FRAMING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WEINKANTZ HARRY CHESSLER BESSIE WETNKRANTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 WOODLING WAY - BALTIMORE, MD 21208 BABETTE CHESSLER / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI CEMETERY 11/11/2004 OWINGS MILLS, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IN WILTIN 0120012 Due to kr as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Dentarient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred

Examiner burial-transit that the death certificate be executed and P.O. Box 68760 the attending physician Physician/Medical ŏ signed by Division of Vital Records, þ þ Completed Be P this filled in by the funeral : After Certification: after death.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

item 27 is marked other then "neturel", or Items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at

the Maryland

72 hours after

filed within 7 Hygiene.

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Importent: if item 27 is marked other the any injury or other traumatic event

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

IF FEMALE 23b. Was decedent pregnant 9 Unknown

Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

5 Pending investigation 1 Natural 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a. Certifier

Medical

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

WQV 1 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

orth was 32. Registrar's Signature

within 24 hours a To the Funerel I

State of Maryland / Department of Health and Mental Hygiene 001 35740 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Marjorie Bowman Cundiff November 8, 7:20 A 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARC Assisted Living Aberdeen Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ STE 214-70-9178 Director 80 June 18, 1924 Virginia Usual Residence of Decedent with the Maryland worke, 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f ahov It e Modical Examiner small be notified at 1 ☐ Yes 2 No Directo Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 691 Custis Street 21001 death v USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 I permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any njury or other traumatic evant, Ite Madic 2006. Elementary/Secondary (0-12) College (1-4or 5+) 2 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Robert Cundiff Charlotte Anna Sheen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blyd., Parkville, MD 21234 Charlotte C. Jones / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 11-11-04 Baltimore, Maryland 21. Signature of Personal Service Incensee 22 Name and Address of Facility
McComas Funeral Home, P.A. 23a. Part 1. Enter the disease, or comprisations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY PRIERY DIJEASE /Medical Due to (or as a consequence of) Examiner 10 4Eng NYPERLIPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and shed for use as the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ₺ No should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. PARKINSONS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an SEIZURE DISORDER this certificate has autoosy performed, 1 Yes 2. No after death.

Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Living 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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	o Physic	ian	Decedent's Name (First, Middle, La	•				2. Date of Dea	ath Day Yea	3. Time of Death
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	23a or					10f. Zip Code)		10g. Citizen of What	Country?
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9	after or Ite		1 Never Married 2 Married	Armed Force	es?	3. Was Decedent of If Yes, specify Cu		rto Rican, etc.)	Black, Wi	hite, etc.
	ural',	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Date	es:	1 □ Yes 2/2 No	o Specify:		Specify:	White
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12	f within 7 piene. r than "n	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	. DO NOT use retir	red)			
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Maryland 21215-0036	2 should be n and Mental is marked reumatic ev	_	19a. Informant's Name/Relationship (19b. Ma	iling Address (Stree	The second second		r, City or Town, State	, Zip Code)
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ore	ages 1 int of He t: If iter y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	•	20b. Place of Dis	position (Name of rematory or other pl	lace)	Date	20c. Location - City of	or Town, State
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Bal	permit. Pages Department of Important: If i any injury or once.		21. Signiture of Funeral Service Licen	SOH		22. Name and Addr MCCOMAS F	ress of Facility uneral Ho	ome, P.A.		
			23a. Part . Enter the disease, or comp	afeline		T2T/ COKE	Sourv Roa	ad. Ahina	don MD 2	
			shock, or heart failure. List only	one cause on each	n line.	inter the mode of dy	ring, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
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× 6	the Dock	/Me	IF FEMALE:	23c. If yes, outcor	ne of pregnancy					
Box	that the death cer ed by the attendir detached for use	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq\text{Yes}\) 2 \(\subseteq\text{No}\)	1 Live birth	2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify)	су		23d. Date of de Month	alivery Day Year
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)	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the besiner: On the basis	st of my knowledge, dea of examination and/or i	th occurred at the ti	ime, date and place	, and due to the ca	use(s) and manner a	s stated.
	To the I within 24 To the I complete	-		and manner	stated.					
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	10		30 Name and address of	ampleted and	ideal (transition)	D ²	10019	l N	Ovember 4	, 2004
	Ŋ		30. Name and address of perso local comparts	MD <	OBATH (Item 23a) (Type	Print)	Devices D. 1	4 - m	. / / 2	1.4
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1tem#10, perFH C83/, 11/12/04 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 2 1 1 1 (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 59 now Kosedol 05 1M0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 213-96-9832 N 2 ☐ F Months Hours Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant, it a Medical Examinating the motified at 1 Yes 2 □ No Director 10g. Citizen of What Country? eet and Number 10f. Zip Code SA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 __No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2☐ Married 1 Yes 2 100 Specify by Specify: 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sud Roxanne 17. Father's Name (First, Middle, Last) Be 2 should be fi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 ts any injury or other trau HO.MD 21202 KETSON Da. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Eun 1 B w. Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metas **Physician** OA eas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physician and use as the burial-transit Due to (or as a consequence of): the attending physician P.O. Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year signed by the atte Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Bo Sma 1 Yes 2 No 3 Probably 4 2 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

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 Funaral Diractor: After t 5 Pending investigation 1 / Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-0060516 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000F1 (.Jeonette Krolikowski unge Drive Balt ONK 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State NOA Registrar

		•	For State Registrar			yland / Dep		lealth and N	Mental Hy	giene 004	
	Physicia /Medica Examine	al -	Decedent's Name (First, Middle, La Rosa Evina A. Facility Name (If not institution, giv	DePaz	number)		1	r Location of Death		Day Yeer 2004 4c. County of De.	1 23:10 M
1/05.	Funeral Director		003-10-3014		7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	Havre De If Under 24 Hrs. Hours Min.	B. Date of Bin (Month, Da 07/17/		ord httplace (State or Foreign country) Lippines
16	death with the Maryland ms 23a or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD	На	rford	Oc. City, Town or L	Be1	camp			10d. Inside City Limits 1
0	th with the 23a or 2 set Le its	Funeral Director	10e. Street and Number 4309 Winners Ci	rcle			10f. Zip Code	21017		10g. Citizen of What C USA	ountry?
9	ō # 1 .		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes.	ecedent Event Forces? Size Market Give To Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spanic Origin? (Spanic Origin) (Specify:	pecify Yes or No Rican, etc.)	14. Race - Arr Black, Wh	
2#	Baltimore, Maryland 21215-0036 Demit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Maportent: If item 27 is marked other than "neturel", or items 23a or 28a-1 show may injury or other treumatic event, the Medical Evaluar must be redifficate and a page.	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	de complete	e (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired HO	ation during most of work the memaker	king	16b. Kind of Busines Own Ho	
M	land in the filed ental Hyge ked othe ic event.	To Be C	17. Father's Name (First, Middle, Last Narcisd T. I	wina						Maiden Sumame) Bacho	
0	re, Maryla s 1 and 2 should t Health and Mer item 27 is marks other treumatic		19a. Informant's Name/Relationship (Lourdes E. Avei							er, City or Town, State, camp MD 210	
83	timore, M Pages 1 and 2 tment of Health tent: if item 27 i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ 1 ☐ Donation 5 ☐ Other (Special		om State		osition (Name of matory or other place ey Cemetery	(e)	Date 5/2004	20c. Location - City of Bonita Cal	
ī	Baltim permit. Par Departmen Importent: any injury once.		21. Signature of Funeral Service Lice	see Vic	tor P.	Doda, Jr. 2	harles L.	Stevens Fun	eral Home Baltimor	, Inc. e MD 21230	
0 0	Physician /Medical Examiner Parallel Physician and e prinal-transit	Examiner	23a. Pert1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due	to (or as a co					rest,	Approximate Interval Between Onset and Death — Man 1hs
Fuina	687 ifficate g phys	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	1 □ Li∙ 4 □ Pr	outcome of ve birth 2 regnant at tir nknown	Fetal death 3	_Ectopic pregnancy			23d. Date of d Month	alivery Day Year
3	ds, P.	d by Phys	Part II. Other significant conditions	-	o death but	not resulting in the c		en in Part I.		obacco use contribute	to the cause of death? Probably 4 □Unknown
205	Record he law requir e has been si	Completed		li	reno	my tre		echon	24a. Was autor perfo	rmed? prior to	utopsy findings available completion of cause of
	f Vital Roysician: The is certificate had director, page	BeC	25. Was case referred to medical examiner?	<i>F</i>)	o Les	ua		26. Place of Dea		ne)	
242	Division of Vital Records, P.O. Box at a transing Physician: The law requires that the death cert death. Director: After this certificate has been signed by the attendin in by the funeral director, page 2 should be detached for use	٩	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. D.	Inpatient ate of Injury Month, Day	2 ER/Outpatie 28b. Time of Injury	of 28c. Injur Wor	y at		dence 6 Other (Sp now injury occurred	ecify)
Del	Divis	Certification	3 Suicide 6 Could not be determined	200. F	lace of Injury uilding, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
	Division o within 24 hours after dath. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying Plant Certify	niner: On th	the best of se basis of e nanner state	xamination and/or in	th occurred at the tire	ne, date and place, pinion, death occur	and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. > e to the cause(s)
	To the Vithin 2 To the Complet	Me	29b. Signature and title of certifier \$\int \text{S29}^n \tag{7}	433	A	B218	29c. Licens			29d. Date signed (Mor	
	3		30. Name and address of person who	on A		th (Item 23a) (Type	Print) e de	Grace	e, M	D 2107	8
	Stat Registra		31. Date filed (Month, Day, Year)	104	2. Registrar'	s Signature	Source	Le la la la la la la la la la la la la la			

		•	For State Registrar	State of M	laryland / Depa	artment of H rtificate of L		Re	g. Ng 0	14 35744
	Physici	an	Decedent's Name (First, Middle, L. Harry Dipi	_{est)}				2. Date of Death Month October		Year 8:30 am M
	/Medic Examin		4a. Facility Name (If not institution, gr 3218 Beverly Drive	ve street and number)	4b. City, Town, or	Location of Death		4c. County of	
	Funeral Director		163-14-4064	Sex 7.A 1	ge (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 31,	Year) 1919	Birthplace (State or Foreign Country) PA
	yland 10W		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	Director	MD N/A			Baltimore	City			1 Yes 2 No
	th with th	ai Dire	3218 Beverly Drive			10f. Zip Code	21214	10	og. Citizen of W	·
36	72 hours after death with the Maryland Instureit, or Items 23s or 28s-1 show Jigst Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	1 No	Was Decedent of Hi II Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene is the state at the state of the then "neturel"; or items 23a or 28a-1 show item 27 is marked other then "neturel"; or items 23a or 28a-1 show other traumetic event. Ite Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest g	Education	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of wor)	king	16b. Kind of Bus	ural Cas Utility
121	filed w Hygier other th		12 17. Father's Name (First, Middle, Las	it)	l W v	NAGER-C		Dispatcher ne (First, Middle, M		n)
Maryland	12 should be fi h and Mental H 7 is marked otl treumetic ever	To Be	Peter Dipietro				Marrie	e Tatton		
	1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship Deverie Lee Halfen			ng Address (Street & 1.8 Beverly I				State, Zip Code)
Baltimore,	a c = =		20a. Method of Disposition 1		20b. Place of Dispondence Commetery, cree	matory or other place	bvember 2	Date 2, 2004	Pittsbur	gh, PA
Balt	permit. Pag Department Importent: i any injury o	-	21. Signatur of Funeral Service Lic	ensee Victor I		2. Name and Addres harles L. S 501 E. Fort	s of Facility Evens Fun Ave. Balt	eral Home, imore MD 21	Inc. 230	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each	ed the death. Do not en line.	ter the mode of dyin	g, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	aCO_	VGES TV.	e HEA	RT F	AILUR	£	
	Examiner		Se vential vlist conditions	6 CO F	CONARY	ARPE	RY C	DISEAS	E	
17.	ted	Examiner	Se uential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s à consequence of):					
8760,	cate be executed oblysician and the burial-transit	al Exar	that initiated events resulting in death) Last	C. Due to (or a	s a consequence of):					
687	ificate I g physi as the L	edica		d		-				
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of delivery th Day Year
rds, P.	quires that on signed by uld be deta	ed by Ph	Part II. Other significant conditions	contributing to death	but not resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	-	bute to the cause of death? 3 Probably 4 Dunknown
Division of Vital Records,	The law reate has bee page 2 sho	Completed by						24a. Was an autops perform	y pr ned? de	fere autopsy lindings available ior to completion of cause of sath? ☐ Yes 2 ☐ No
Vita	Physicien: r this certifica ral director,	Be	25. Was case referred to medical examiner?	Hospital:		othi	ac	ath (Check only on	1	
of	Phys r this eral dir	To :	1 ☐ Yes 2/1 No 27. Manner of Death	28a. Date of In (Month, D		nt 3 DUA	4 Nursing F	lome 5 Reside 28d. Describe ho		
ion	Attending r death. ector: After by the fune	atior	1 Natural 5 □ Pending 2 □ Accident investigat	ion	Day Year) Injury		(? Yes 2 □ No			
Divis	el or Atto s after de il Directo od in by tl	Certification; To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of h	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (St. City or Town	reet and Numbe , State)	r or Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical C			st of my knowledge, dear of examination and/or in stated.					
	To th within To th compl	Me	29b. Signature and title of certifier		1. 0	29c. License		ŧ		(Month, Day, Year)
			30. Name the address of person wh	o completed cause of	death (Item 23a) (Type	Print)	+1637			29/04 , MD 2/2/8,
	6	-	3333 N.	CALVERT	ST - SU	IVE 650J	PB -	13501)	(PU LE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Sta Regist		31. Date filed (Month Day Yar) 2.	2004	krar's Signature	fore	as a			

DHMH 17 Rev 1/2001

		1 - State Registrar		Ce	rtificate of L	Death	Reg.	No2004	35765	
hysici /Medio		1. Decedent's Name (First, Middle, Las Stewart L. Dains					2. Date of Death Month November	Day Year	3. Time of Death	
xamir		4a. Facility Name (If not institution, give Doctors Hospital.	street and number)			Location of Death		4c. County of Deat	h rince Georges	
ineral ector		5. Social Security Number 6. Se 403–47–6096	7. Age (I	n yrs. last birthday) 70	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, Ye 10/06/19	ar) 9. Birt Co	hplace (State or Foreign untry)	
show d at	ı,	Usual Residence of Decedent 10a. State 10b. County ON Or	ntario	Oc. City, Town or Lo		Carlisle			10d. Inside City Limits	
or 28a-f be nutifie	Director	10e. Street and Number	78 Carlisle		10f. Zip Code	OR 1H1	10g.	Citizen of What Co		
items 238	Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Yes 222No	er in U.S. 13.		spanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	rican Indian,	
al Exam	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes ŽŽNo dent's Usual Occupa	Specify:	100	Specify:	white	
neve l	Completed	(Specify only highest grant Elementary/Secondary (0-12)	(Give	kind of work done of DO NOT use retired, Truck Dri	luring most of working)	7	16b. Kind of Business/Industry Transportation			
	Be	17. Father's Name (First, Middle, Last) James Dainard				18. Mother's Name	First, Middle, Maid Stewart			
	2	19a. Informant's Name/Relationship (7 Diane Dainard / With			ng Address (Street a	nd Number or Rural Carlisle		ty or Town, State, 2	(ip Code)	
		20a. Method of Disposition 1								
any inju		21. Signature of Funeral Service Licen		oda, Jr. 2	Name and Addres harles L. S	s of Facility tevens Funer Avenue, Bal	al Home, I	nc. 21230		
ian		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	e death. Do not ent					Approximate Interval Between Onset and Death	
lical iner	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Myr	onsequence of): onsequence of): onsequence of):	Q/W	anction	V			
should be detached for use as the burial-transit	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of a 1 □ Live birth 2 € 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
ld be deta	by P	Part II. Other significant conditions co	ontributing to death but n	not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacc		the cause of death?	
, page 2 shou	Completed	Caravanj	Arter	y D	(Seasc	>	24a. Was an autopsy performed 1 Yes 2	? prior to death?	topsy findings available completion of cause of	
completely filled in by the funeral director, page 2	ıtlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yo	2 ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	at 28		6 ⊡Other (Specialized)	rify)	
£	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office	28	f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,	
d in by	O									

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 2 2004

32. Registrar's Signature & January

		For State Registrar	State	of Marylan		artment rtificate					ene g. No. 20 () 4	35	746
Physicia	_	1. Decedent's Name (First, Middle Palma Mary Di							2	Date of Death	r ^D , 200	724	3. Time o 5:45	
/Medica Examine		4a. Facility Name (If not institution 1701 Parkvue I		umber)			fown, or	Location o			4c. County of	Death		-
Funeral Director		5. Social Security Number 216-09-2005	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 85	last birthday) Yrs.	If Under	Year	If Under Hours	Min.	Date of Birth (Month, Dey, Dril 13	Year) , 1919	Birthpla Countr Mary	$^{ ext{ce}}_{y)}^{ ext{ce}}$	or Foreign
Maryland 9-f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Har:		10c. Cit	ty, Town or Lo	cation .1ston						100	d. Inside C	ity Limits
der death with the Marylan after 23e or 28e-f show	ai Director	10e. Street and Number 1701 Parkvue l	Road			10f. Zip (Code	2104	7		g. Citizen of What U.S.A.	t Countr	y?	
S & 2	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried Armed F	2 ⊠No ive		Was Decede f Yes, speci 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		y Yes or No- can, etc.)	14. Race - Bleck, ' Specify:	America White, et	c.	
IG 27215-0036 filed within 72 hours at 1 Hygiene. other than "naturel", or rent, Ire Mudical Exert	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 6 years) (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	l Occupa k done d e retired;	ition luring mos)	t of working		6b. Kind of Busing		·	
ed it b	Be	17. Father's Name (First, Middle, Last)							First, Middle, M	eiden Sumame)				
re, Maryland s 1 and 2 should be file t Health and Mental Hy item 27 ls marked oth other treumatic event	၉	19a. Informant's Name/Relations	ship (Type, Print)			-		nd Numbe	er or Rural R	Route Number,	City or Town, Sta		Code)	
ore, es 1 an of Heal ritem 2		Joseph DiGuard 20a. Method of Disposition 1 1 Burial 2 □ Cremation	_	20b. F	I / U I Place of Disponentery, crer				Palls		d. 21047 oc. Location - Cit		n, State	
ting the standard signal		*4 □Donation 5 □Other (5	Specify)	Par	rkwood	. Name and	Addres	s of Facilit			Baltimo			
Dermi permi Depar Impo any ir		23a. Part1. En er me di ea e, oi	r complications that	caused the deat	th. Do not ent						Bel Air Air, Mo		1C. 01/ ₁ Approximat	10
Certificate be executed Americal Examined Physician and Isse as the burial-transit	Ical Examiner	shock, of hart farur. List Immediate Cruse (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to		quence of):		ell	~		#17.50	E-807 &	(nterval Bet Onset and	
death certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 Live	utcome of pregna birth 2 Fete gnant at time of d nown	el death 3	Ectopic pre Other (spe					23d. Date o Month			Year
es a ge es es es es es es es es es es es es es	þ	Part II, Other significant conditi	ons contributing to	death but not res	sulting in the w	nderlying ca	use give	n in Part I.			acco use contribu	te to the		death? Unknown
The ate h	Completed									24a. Was an autopsy perform	ed2 deat	to comp	y findings pletion of c	available ause of
n of VIta ng Physicien fler this certific	ertification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir investi 2 Accident investi 3 Suicide 6 Could determ	Hospital: 1 28a. Date (Mor	e of Injury nth, Day Year) e of Injury - At he		28 M	lc. Injury Work 1 🗆 Y	r: 4 🗆 Nu	rsing Home 28d	Describe how Location (Stre	ice 6 Other (Route Num	iber,
DIVISIO To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tu	O	29a. Certifier 1 → Certifyin	ng Physician: To th	ding, etc. (Specif	owledge, death	occurred a	t the tim	e, date an	d place, and	City or Town,	ise(s) and manne	r as stat	ed.	
o the Ho ithin 24 t o the Fu	Medical	(Check only 2 Medicel one) 29b. Signature and title of certifie		basis of examina	ation and/or in			number	th occurred		e and place, and)
F 3 F 8) luft	Alt	1 AP			28		1		11/10/	24		
10		30. Name and address of person	okalm	UD 20	6 He	Print)	5+	Be	A L	bM 1	2101	+		
Stat Registra		31. Date filed (Month Pay, Year)	2804	Registrar's Signa	ature	off of								

			1- State Registrar AMEND ITEM #23a PER PHY C837 PIT FLORIDA OF THE AMEND ITEM #23a PER PHY C837 PIT FLORIDA OF THE PHY PHY PHY PHY PHY PHY PHY PHY PHY PHY	ental Hygie	- 00 -	35747
			1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
н	Physici: /Medic		MARGARET DAVIDSON	Month 11 03	3 2004	2:10 A M
	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	1
			MARINER HEALTH OF FOREST HILL FOREST HILL		HARFORE)
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Cou	nplace (State or Foreign untry)
	Director		201-01-8857 West State of Decedent	6-27.	AR TIAD	SAUGHTOD, KA
	yland yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mar.	tor	MID HARFORD FOREST HILL			1 ☐ Yes 2 No
	th the)ire	10e. Street and Number 10f. Zip Code	10g.	. Citizen of What Cou	untry?
	23e	rai	COLGATE DRIVE 21050		USA	
	er des	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Amer Bleck, White	ican Indian, , etc.
36	rs aft	by F	1 Never Married 2 Married		Specify:	XLL.TE
21215-0036	72 hours after death with the Maryland natural', or Items 23e or 28e-f show Jical Examinat must be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	168	b. Kind of Business/I	ndustry
2	within 7 ene. than "n	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)	19	1 - 0	
	e filed within al Hygiene. I other than ' vent, tre Me	Con	2 NURSE	 	EALIA C	ARE
nd	be fill d oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Mai	den Sumame)	. 1. 5./
$\frac{8}{5}$	should be nd Mental marked o	Ļ	PRED CARIER ESORA	500	AMEL	A LUNDY
Maryland	d 2 sho th and th and 7 is ma treum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 105 North way	I Houte Number, C.	rty or Town, State, 21	DV2 VW
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other treumetic event, I'm Medical Espainer must be notified at			ate 200	c. Location - City or T	own, State
Baltimore,			1 Burial & Cremation 3 Removal from State 4 Donation 5 Other (Specify)	4 F	SOUST L	W/ MD
al E	permit. Page Department of Importent: If any injury or once.			AN FUNE	RAL CHY	19-1-REL
m	permi Depa Impo any it		MOIZZO 3 NEWPORT DR	IVE FO	REST HILL	- MD 21000
П			23a. Pan1. Enter the disease opcomplications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest,		Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition Anorexia	ı		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	ZXGIIIIIO	-	Sequentially list conditions, and any, leading to arminidate b. Due to (or as a consequence of,)			
Ví	nsit	mine	cause. Enter Underlying Cause (Disease or injury			
Š	exectin and ial-tra	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
68760,	icate be executed physician and sthe burial-transit	edicai	d			
_	ntifica ng ph s as th		IF FEMALE:			
Вох	death certi e attending ed for use a	lan/l	23b. Was decedent pregnant in the past 12 months?		23d. Date of deliv	rery Day Year
P.O.	n requires that the death certif been signed by the attending should be detached for use a	Physician/M	1 Yes 2 No 9 Unknown Unknown The control of death 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 Yes 2 No 9 Unknown 1 Yes 2		, worth	Day Tou
	The law requires that the ate has been signed by the page 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Sp.	uires n sign IId be	d by	Gastrointestinal Bleed	1 🗌 Yes	2 No 3 Pro	bably 4 Unknown
00	s beel	iete		24a. Was an	24b. Were aut	opsy findings available
Be	The la te ha	Completed		autopsy performed	death?	ompletion of cause of
Division of Vital Records,	ien: rtifica	BeC	25. Was case referred to medical 26. Place of Death		10 10169	215/10
<u>}</u>	Physicien: r this certifica ral director, I	To	examiner? 1 Yes 2X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: AN Nursing Home	ne 5 🗌 Residence	e 6 □Other (Speci	fy)
פֿח	ing P	on:	i Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe how i	njury occurred	
<u>s</u>	Attending ir death. ector: After by the fune	icati	2 Accident investigation M 1 Yes 2 No	IRE I service (Charac	4	10 11 11
$\frac{1}{2}$	l or A after Direc	Certification	determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	t and Number or Rur. tate)	al Houte Number,
	e Hospitel 24 hours a e Funerel I etely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, at	nd due to the cause	e(s) and manner as :	stated.
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	d at the time, date	and place, and due t	to the cause(s)
	To the I within 2 To the I complet	Ĭ	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
			Daw 5 Dun 132255	(d)	avenher	3,2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			,
			31. Date filed (Month, Day, Year) 32/Registrar's Signature	1014		
	Sta Registr	Υ.	31. Date filed (Month, Day, Year) 32/Registrar's Signature Sports			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 35748 1 - For State Registrar Certificate of Death dent's Name (First, Middle, Last 2. Date of Death Month 3. Time of Death Year ASTRO VOVONBak 2004 4d. dounty of Death 4a. Facility Mame (If not institution, give street and number) 4b. City, Town, or Location of Death BAD e LAY ALTIMOR 9. Birthplace (State or Foreign Country) If Under 1 Year VII Under 24 Hrs. Social Security Number 6. Sex / 1 → M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 215 39 6104 53 Yrs. Philippines Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Relay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5114 S. Rolling Road 21227 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ∑XNo If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1. Yes 2. No Specify: Filipino 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Billing Medical Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jose DeCastro Carmen Arellano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josefina Alonso/Sister 3130 Edgewood Road Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 11-11-2004 Catonsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee /) M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INSTANT 23d. Date of delivery Month Day Year

Physician /Medical Examine

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

or 28a-f show

Pages 1 and 2 should be fited within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, it a Medical Examinat must be notified at

and Mental Hygiene.

permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is any injury or other trau once.

Completed by Funeral Director

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

<u></u>	
Examine	
by Physician/Medical	
ompleted	
o Be Co	
Sertification: To	
1	1

Immediate Cause (Final disease or condition resulting in death)	a. Sign Shot Wound to hop? Due to (or as a consequence of):							
Sequentially is a conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequence of):	-						
that initiated events resulting in death) Last	c. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown							
Part II. Other significant condition	is contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco						
		24a. Was an autopsy performed?						
25. Was case referred to medical examiner? 1 D Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	Check onl ne						
27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year) 1 1 Yes 2 10 No	Self I						
3 Suicide 6 ☐ Could no 4 ☐ Homicide determin		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify).						

home

6 ☐Other (Specify)

ury occurred

OAd 5114 5 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

use contribute to the cause of death? 3 Probably

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

4 Unknown

WILL,

State Registrar

filled in by the funeral

after death.

within 24 hours a To the Funeral C

31. Date filed (Month, Day, Year) NOV 1 2 2004

32. Registrar's Signature

DHMH 17 Rev 1/2001

			For State Registrar		State of	Marylan	d / Depa <i>Ce</i> a	artment rtificate	t of H	ealth a	and M	lental Hy	gienez	004	35749
	Physici	an	Decedent's Name (F	irst, Middle,	Allen	F. Duke	man J	r				2. Date of De Month Novemb	eath Day	, ž°o	3. Time of Death 8:20 PM
	/Medic Examir		4a. Facility Name (If no			nber)	marry 0	4b. City,			of Death		4c. C	ounty of Death	
	Funeral Director		5. Social Security Number 213 26 1	per 6		7. Age (In yrs. 7 5	last birthday) Yrs.	If Under Months		If Under Hours		8. Date of Bir (Month, De June 2	th 17, Year) 0,1929	9. Birthy Cou	place (State or Foreign ntry) Vland
44	the Maryland 28e-f show	7.		b. County			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ※ No
51-5	death with the Maryland rms 23a or 28e-f show froust be notified at	Director	Maryland 10e. Street and Number 7545 Div		creek Ro			10f. Zip	Code 2185	51			_	n of What Cou	
113-21	e # 2	/ Funeral	11. Marital Status 1 Never Married	2X Married	12. Was Dece Armed Fo	dent Ever in U ces? 2 (X)No		Was Deced	ent of Hi ify Cuba			ecify Yes or No Rican, etc.))- 14	. Race - Americ Black, White, pecify: Whi	etc.
20	5-0 72 ho 72 ho	Completed by	(Specify	. Decedent's only highest	Year or Da Education grade completed)	ites:	16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa	ition	-	ing		of Business/In	
Dukeman	re, Maryland 21215-0 s 1 and 2 should be filed within 72 ho I Health and Mental Hygiene Item 27 is marked other than "natur other traumatic event, the Medical	Be Com	6th 17. Father's Name (Fin		College (1	-4or 5+)	Cas	shier		18. Moth	er's Name	e (First, Middle			ce Store
Duk	arylan	ToE	Allen F. Dukeman, Sr. Gertrude Andersen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number, City or Tow								own, State, Zip				
	lore, M ges 1 and 2 it of Health If item 27 or other tr		Joan Duk 20a. Method of Disposi 1 🖾 Burial 2 🗆 🖸	tion	Wife Removal from 5	State	lace of Dispo emetery, crea	sition (Nam matory or of	e of ther place	9)	C	Date		, Mary]	Land 21851 own, State
	Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event, the Mance.		* 4 □ Donation 5 [21. Signature of Funer	al Service Lie		Me	,	dge Me 2. Name and 001 R:	d Addres	s of Facili	ity Go	nce Fur	neral	Service	Maryland P.A.
	Physician		23a Part1. Enter the c shock, or heart fa	disease of co	omplications that cally one cause on ea	aused the deat ach line.		er the mode	of dying	j, such as				e, Mar	yland 21225 Approximate Interval Between Onset and Death
	8760, cate be executed xx bysician and minimize the burial-transit	dicai Examiner	disease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter Underlyit Cause (Disease or injuthat initiated events resulting in death) Last	ions, diate ng ry	b	or as a consequence or a consequence or a consequ	uen don:	√;ve ula	2 1 - 1	Head Head	A t	Fair Dis	luve aase	>	
	Division of Vital Records, P.O. Box 6i or Attending Physician: The law requires that the death certificate death. Director: After this certificate has been signed by the attending prin by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent print the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	nths?		irth 2 ⊡Feta ant at time of d	Ideath 3	Ectopic pre Other (spe					230	d. Date of delive Month	Day Year
	cords, P. (w requires that the state of the signed by should be detact		Part II. Other significa	nt condition	s contributing to de	ath but not res	ulting in the u	nderlying ca	iuse give	n in Part I	l.		obacco use	_	ne cause of death?
	I Reco The law reate has bee	Completed										24a. Was auto perfo	an 2 osy ormed? 2 No	24b. Were auto prior to con death? 1 \(\subseteq \text{Yes} \)	psy findings available mpletion of cause of
	f Vital F ysician: Th ys certificate director, pag	To Be (25. Was case referred examiner? 1 ☐ Yes 2 ☐ No	to medical	Hospital: 1 🗆 li	npatient 2	ER/Outpatier	nt 3 DO	A Othe	•		me 5 Resi		Other (Specifi	v)
3	Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate th completely filled in by the funeral director, page	ation;	2 Accident	Pending investiga	tion	of Injury h, <i>Day Year)</i>	28b. Time of Injury	M 28	Bc. Injury Work 1 🗆 Y	at ? ′es 2□		28d. Describe	how injury o	ccurred	
1	Divisi To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	4 Homicide	Could no determin	ed 200. Flace buildir	of Injury - At he	y)					City or To	wn, State)		I Route Number,
4	the Hospital thin 24 hours a the Funeral mpletely filled	Medical	29a. Certifier (Check only one) 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Medicel Ex	Physicien: To the ceminer: On the ba and mann	isis of examina	wiedge, deati tion and/or in	vestigation,	it the tim in my op License	inion, dea	nd place, a ath occurr	and due to the ed at the time,	date and pla	d manner as st ace, and due to igned (Month,	the cause(s)
	To Viit Viit Viit Viit Viit Viit Viit Vii		•	July	All	nu)	102e) T				320	60			-
			30. Name and address 31. Date filed (Month,	hu	white	ker,	MUD	^{7 (1)} 5	05	Pos	come	treet colee Co	Su Je,	MD	-04 21851
	Sta Regist	ate rar	NOV	1 2 20	04	egistrar's Signa	LUI O	10					. ,		

	1 - State State C	of Maryland / Depa	artment of Herificate of L	ealth and Mer Death		en2004	35750
	Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death
Physician /Medical	Albert Henry Dudley, Jr.				ovember	10 Year 200	4 10:00 P ^M
Examiner	4a. Facility Name (If not institution, give street and no		4b. City, Town, or	Location of Death		4c. County of Death	
8	Oak Crest Village - Care		Parkvi1			Baltimore	
Director	5. Social Security Number 6. Sex 1217-18-5770 12 F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Y arch 12		place (State or Foreign Intry) rginia
Maryland Maryland	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
1 / 10 / 0 / 10 / 0 / 10 / 0 / 0 / 0 / 0	Maryland Baltimore	Parkvi1					1 ☐ Yes 2 👿 No
the the rect	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	
5 11 10 0 C. I street death with the Main ritems 23e or 28e-1s of treet must be notified. Funeral Director	8810 Walther Blvd.		21234		U	nited Stat	tes
	11. Marital Status 12. Was Dec	edent Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Specify n, Mexican, Puerto Rica	Yes or No-	14. Race - Amer Black, White	
affer affer /Fu	1 ☐ Never Married 2 Married 1 MYes	2 🗆 No	1 ☐ Yes 2 🛣 No		an, etc./	Specify:	, etc.
15-0036 17-2 hours after "natural", or its added Examira	3 Widowed 4 Divorced Year or [Dates: 1947-51				wh	ite
6	15. Decedent's Education (Specify only highest grade completed,	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	luring most of working	16	ib. Kind of Business/Ir	ndustry
vithi iene. There	Elementary/Secondary (0-12) College (1-4or 5+)	octor			Medical	
other other of the C	17. Father's Name (First, Middle, Last)		3332	18. Mother's Name (Fi	irst, Middle, Ma		
Maryland 2121 Maryland 2121 and 2 should be filed within the and Mental Hygiene. 77 is marked other then? 11 traumatic avant, ITEMS	Albert Henry Dudley, Sr.			Lily Gaine	es		
2 sho and I amme aume	19a. Informant's Name/Relationship (Type, Print)		-	and Number or Rural Ro			
and and lealth her tr	Carol Dudley/wife	20b. Place of Dispo	Walther	BIVd. Par	rkville		
Baltimore, sermit. Pages 1 are Department of Head Department of Head Individual: If item my injury or other page.	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from	State cemetery, cres	matory or other place	9)		c. Location - City or T	
It. Partition of injury	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Greenmour	nt cremato	ory Nov. 12	,2004 B	altimore,	Maryland
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic avance.	John O. Mitchell		0000 1		Battino	re, MD ZI	Inc. 212
	23a 111. Enter the disease, or complications that nock, or heart failure. List only one cause on	caused the death. Do not ent each line.	A		spiratory arrest	t,	Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	ebvovascu	lan Ac	cident			Onoot and Boats
/Medical Examiner	Due to	(or as a consequence of):					
<u>.</u>	Sequentially let conditione, if any, leading to immediate Due to	(or as a consequence of):					
D, executed an and rial-transit	Supuritially liet so utilibrie, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
	resulting in death) Last Due to	(or as a consequence of):					
18760 cate be e physician i the buria	d						
	IF FEMALE:						
Box 6.	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Records, P.O. Box 6 The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as completed by Physiclan/Me	1 Yes 2 No 4 Preg 9 Unknown 9 Unkn		Other (<i>specify</i>)				
ds, P. Lires that the signed by doe deta	Part II. Other significant conditions contributing to				23e. Did tobac	cco use contribute to	the cause of death?
rds, quires the signer and be conditioned by	Coronary U	item D	1 Slase		1 🗆 Yes	2 No 3 Pro	bably 4 Onknown
ecord aw requir s been si 2 should	J				24a. Was an	24b. Were auto	opsy findings available
II Record The law requir					autopsy performed	d? death?	ompletion of cause of
Vital Recsition: The law contilicate has be rector, page 2 so Be Comple	25. Was case referred to medical examiner?			26. Place of Death (C)			
of Vita Physician: r this certifical ral director,	1 Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatier		4 Vivursing Home		ce 6 □Other (Speci	fy)
on of Vital ding Physician: h. After this certifica funeral director,	Tenatural Solitaring	of Injury 28b. Time o hth, Day Year) Injury	Work		. Describe how	injury occurred	
Division of Vital Records, for Attending Physician: The law requires talter death. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by	2 Accident investigation 3 Suicide 6 Could not be 28e Place	e of Injury - At home, farm, str		/es 2 □ No	Location (Stree	et and Number or Run	al Route Number
Division C tal or Attending P rs after death. al Director: After i ed in by the funer:	4 Homicide determined build	ling, etc. (Specify)	001, 1201019, 011100		City or Town, S	State)	
Division To the Hospital or Attending within 24 hours after death. To the Funaral Director: After compissely filled in by the fune Medical Certification	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medicel Examiner: On the land man	e best of my knowledge, deat pasis of examination and/or in the stated.	h occurred at the time vestigation, in my op	e, date and place, and pinion, death occurred a	due to the caus at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
Fo the within For the comple	29b. Signature and title of certifier		29c. License	number	29d.	. Date signed (Month,	Day, Year)
- I	> DX M		D3	2687		ulul	04
- 9	30. Name and address of person who completed ear	se of death (Item 23a) (Type)	Print) B	od Par	Kalle	MO2	1236
State Registrar	31. Date filed (Month, Day, Year) 32.4 NOV 1 2 2004	Registrar's Signature	Sparks	/	400		

			1 - For Stete Registrar	State of Ma		rtment of Heal		ntal Hygiene	2004	35751	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Aidan Matt	new Do	ugherty			Date of Death Month Da	y Year 1 2004	3. Time of Death	
	Examin		4a. Facility Name (If not institution, give s Johns Hopkins	Hospita		4b. City, Town, or Local Baltimo	ore	4-	Baltin		
	Funeral Director		5. Social Security Number 6. Sex 214-69-8900 XX	7. Age	(In yrs. last birthday) Yrs.	Months Days Hou	nder 24 Hrs. 8. urs Min. De	Date of Birth (Month, Day, Year) COMDEY 28,	2003 Ma	hplace (State or Foreign untry) ryland	
	Maryland 1-f show illed at	tor	10a. State 10b. County Maryland Baltimore		10c. City, Town or Lor Baltimore					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	th with the 23a or 28i	al Direc	10e. Street and Number 1831 Loch Shiel Roa			10f. Zip Code 21234		10g. Cit	izen of What Co USA	untry?	
980	be filed within 72 hou lal Hygiene. d other than "natura avant. It e Moulce!	by Funeral Directo	11. Marital Status XXNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes XX No If Yes, Give Year or Dates:)	Vas Decedent of Hispani Yes, specify Cuban, Me □ Yes XX No Spe	c Origin? (Specify xican, Puerto Ric ecify:	y Yes or No- an, etc.)	14. Race - Ame Black, White Specify:		
Maryland 21215-0036		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+	(Give	ent's Usual Occupation kind of work done during OO NOT use retired)	most of working	16b. K	ind of Business/l	Industry	
yland		To Be (17. Father's Name (First, Middle, Last) Matthew Daugherty	′				irst, Middle, Maiden 11SE LEWIS			
e, Mar			19a. Informant's Name/Relationship (Tyx Matthew Daugherty	•	ther 1831	Address (Street and No Loch Shiel	Road Ba	ltimore,	Marylan	d 21234	
Baltimore,	t. Pages 1 rtment of h rtant: If ite		20a. Method of Disposition 1		Dulaney Val	ley Mem Gar	•	'04 Lut		e, Maryland	
Ba	perm Depa Impo any i	21/ Ignature of Funeral Service Licensee 22. Name and Address of Facility Mitchell—Wiedefeld Funeral Home In 6500 York Road Baltimore, Maryland 212 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately 1975 Approxi									
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hepatic Failure Due to (or as a consequence of):							Interval Between Onset and Death 8 mcm+n5	
	Examiner	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cys	tic Fibe	osis				11 months	
8760,	icate be executed physician and s the burial-transit	dical Exar	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
.O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year	
S, D	w requires that been signed by should be deta	by	Part II. Other significant conditions con	tributing to death but	not resulting in the un	derlying cause given in P	Part I.			the cause of death?	
Vital Record		Completed				*		24a. Was an autopsy performed?	24b. Were aut prior to o death? 1 \sum Yes	opsy findings available ompletion of cause of 2 'No	
on of Vita	uing Physician: Th	To Be	27. Manner of Death 1 Natural 5 Pending	ospital: Inpatient 28a. Date of Injury (Month, Day)	28b. Time of	Other	28d.	heck only one) 5 Residence Describe how injure		ify)	
Division of	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Location (Street an City or Town, State		ral Route Number,					
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Cartifier (Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of a and manner state	examination and/or inv	occurred at the time, dat estigation, in my opinion,	te and place, and death occurred a	due to the cause(s)	and manner as place, and due	stated. to the cause(s)	
	To the Within	M	29b. Signature and title of certifier	. ~		29c. License numb			e signed (Month		
	5		30. Name and address of person who con Megan E. McCa	be 600	ath (Item 23a) (Type, F	fe St.	Baltin			387	
==	Sta Registr		31. Date filed (<i>Month, Day, Year</i>) NOV 1 2 2004	32. Registrar	's Signature	fe St.			-		

State of Maryland / Department of Health and Mental Hygiene 0 0 1 35752 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** FIGENBROT 15:00 PM Jovember 8 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Sinai Hospital of Baltimore 8. Qate of Birth APR. 6, 1921 Baltimore ()
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 🙀 F 83 NY 059-14-7128 Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumetic event, the Medical Exercities round to notified at Director PIKESVILLE 1 ☐ Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1838 REISTERSTOWN ROAD #216-A 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/IndustMARKETING 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is markad other than "r Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** PUBLIC OPINION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **EISENBERG ESTHER** GREENBERG MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health an.
Important: if Item 27 Is m. any highly or other 9 OLD MAPLE COURT - BALTIMORE, MD 21221 LAURENCE DESI / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEMORIAL | 11/10/2004 REISTERSTOWN, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Probable Seizure Disorder disease or condition resulting in death) 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atherosclenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 217No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to-medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical vietela 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title o November 8, 2004 ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Hospital of Baltimore State Registrar

Eigenbrat

Patient Known as

			1- For State of Maryland / Department of Health and Me Certificate of Death	ental Hygier	/ III II II	35753
	Physici /Medic		JAME FREEMAN	2. Date of Death Month E	Day Year 3 2004	3. Time of Death 2.16 PM
	Examin			4	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F R R R R R R R R R R R R R R R R R R	Date of Birth (Month, Day, Yea MARCH 2//	9. Birthp Cour	place (State or Foreign (Sty)
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Bylimups		1	0d. Inside City Limits 1 ✓ Yes 2 □ No
	with the h a or 28a- be notifi	Direct	10e. Street and Number 10e. Street and Number 10f. Zip Code 1/206	10g. (Citizen of What Cour	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel" or itams 23a or 28a-f show important: if item 27 is marked other than "naturel" or itams 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at once.	by Funeral Director	HYO FRANK fand AVE J Zo G	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
21215-0036	ithin 72 houn ne. nen "naturaf" nedical Ex	Completed b	3 A Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	7	Kind of Business/Ind	
Maryland 21	ild be filed with lental Hygiene kad othar tha itc evant, the	To Be Cor	17. Father's Name (First, Middle, Last)			
	1 and 2 should be Health and Mental ism 27 is markad of other traumatic even		19a Info ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F 19c. Land Local AVE 19b. Mailing Address (Street and Number or Rural F 19c. Land Local AVE 19c.	Route Number, City Baldimake	MO 2/20	4
altimore,	. Pages 1 Iment of H tant: If itan jury or oth		20a. Method of Disposition 1 Sourial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Albuts Memmal 1//6	114 E	Location - City or To	1d
Bal	permit. Pag Department Important: 1 any injury o		Sotterio Beets 1129 N. CANSIME St	BAH	more Mon	21213
	Pnysician /Medical	X N	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or restricted to the such that the su		Tien o	Approximate Interval Between Onset and Death INKAULUA
	Examiner	er	Sequentially list conditions b.			
8760,	The law requires that the death certificate be executed the saben signed by the attending physician and page 2 should be detached for use as the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Box 687	leath certificate attending phys	Physiclan/Medical	d. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delive	
P.O. B	that the dea led by the att detached fo	hysicl	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown		Month	Day Year
	w requires that been signed should be de	by	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.		use contribute to the	ne cause of death?
Vital Records,	The law recate has be page 2 shi	Completed		24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
f Vita	Physician: The la r this certificate has aral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 1 Nes 2 1 Nes 1 1 1 1 1 1 1 1 1		6 □Other (Specify	()
Division of	Attanding Port death. ector: After to by the funera	Certification:		d. Describe how inj	ury occurred	
Ö.	vital or Attano urs after death ral Director: lled in by the			City or Town, Sta		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical		at the time, date a	nd place, and due to	the cause(s)
)	To Vill				ate signed (Month, i	
_	4		Steptes Server M. Doo 4265 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN G. HOATECLAW, MD 560/ LOCH RAVEN BO	OULEVARD	BAKTIONES,	21239 814844V
	Sta Registi		A section of the sect			

			1 - For Registrar	State of Mar	yland / Depa <i>Ce</i>	artment of F	leaith and l Death		giene 2004	3575
	Physic:		Decedent's Name (First, Middle, Last, Alice Teresa Fren	•				2. Date of Dea Month Novembe	ath Year	3. Time of Death
}	Examir		4a. Facility Name (If not institution, give Riverview Care Cer		-	4b. City, Town, o	r Location of Deat		4c. County of Death Baltimor	h
Í	Funeral Director		212 05 0551	7. Age ((In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day March 2	9. Birth (7, 1906 Mary	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-1 show out, I'm Medical Examiner must be required at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 10e. Street and Number	1	Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ath with	ral Dir	1605 Howard Avenue	فِ		10f. Zip Code 21221			10g. Citizen of What Cou USA	antry?
036	ours after des al', or Items Examiner m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 🏖 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Whi	e, etc.
9500-6121	d within 72 hours after death with the Marylan jene. r than "natural", or Items 23s or 28a-1 ehow I'm Medical Examiner meat be redified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> Colfege (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired Secretary	during most of wor	rking	16b. Kind of Business/I	ndustry
Jana	a la la	To Be Co	17. Father's Name (First, Middle, Last) Clarence Strasing	er		beeretary			Aerospace Maiden Sumame)	
e, mary	nd 2 sho aith and A 27 is ma r trauma		19a. Informant's Name/Relationship (Ty John French (Son)	pe, Print)	1505	D. West C		es Ocala	r, City or Town, State, Zi, , Florida 3	
saltamore	t. Pages rtment of rtant: If it		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Parkwood	Cemetery	11/1:	3/2004	20c.Location-City or T Baltimore, 1	
D D	Dermi Depa Impo		21. Signature of Funeral Service License 23. Part. Enter the disease, or compli	kowske	/ 1	ruzdzinsk 407 Old E	astern A	venue Es	sex, Md. 21	221 Approximate
で	Physician /Medical Examiner	Examiner	spock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	ohic (7		teny disease	Interval Between Onset and Death Onset and Death CM - (M.Dw)
.o. box oo/ou,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical E	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2∑No 9 □ Unknown	Due to (or as a c	pregnancy Fetef death 3	Ectopic pregnancy			23d. Date of delive Month	ery Day Year
COIDS, T	quires that en signed b	þ	Part II. Other significant conditions con Surpt Ned	tributing to death but n	not resulting in the ur	derlying cause give	n in Part I.	. ("	pacco use contribute to the	
משבו וג	aician: The law re s certificate has be- lirector, page 2 sho	Completed	Peripherol Dementio	Vascus	las di	serie	/	24a. Was ar autops perform 1 Yes 2	y prior to co. ned? death?	opsy findings available impletion of cause of
10 10 10	ing Phy Iter this uneral d	atlon: To Be	27. Manner of Death 1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 🖸 Nursing Ho	th (Check only only only only only only only only	nce 6 Other (Specifi	iv)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Injury building, etc. (S	Specify)			City or Town		
	o the Hosp ithin 24 ho o the Fune ompletely f	Medical	29a. Certifier (Check only one) 2 Gertifying Phys 2 Medical Examin 29b. Signature and title of certifier	ician: To the best of m ier. On the basis of ex- and manner stated	amination and/or inv	occurred at the time estigation, in my op	inion, death occur	red at the time, da	ate and place, and due to	the cause(s)
	n	ì	30. Name and address of person who cor	moleted cause of deat	(Item 23a) (Type F	D38754		1	ovember 12,	
mag)	Sta		Dr. Malika Waseem N 31 Date filed (Month, Day, Year)		stern Bou	levard Ba		Marylan	d 21221	
	Registra	ar	NOV 1 2 2004	Densen	D	sports				

DHMH 17 Rev 1/2001

		-	For State Registrar	State of Mar	yland /	Departme Certifica	nt of H	lealth and	Mental Hy	/giene Reg. No.		35755
	Physicia	an	Decedent's Name (First, Middle, Last						2. Date of D Month	Day		3. Time of Death
	/Medic	571	4a. Fecility Name (If not institution, give	FIMPLE		4b. Cit	v. Town, or	Location of De	16ath	2 3 4c.	County of Dea	
	Examin	er			AB		SA	Libbory			nic.	
	Funeral Director		5. Social Security Number 6. S	ex 7. Age ((In yrs. last b	yrs. If Unc	der 1 Year s Days	If Under 24 H Hours Mi		irth ay, Year)	9. Bir	rthplace (State or Foreign country) nnsylvania
	ס		Usual Residence of Decedent						joury 1	, ,	.52 10	
	Marylan I-f ehow fied at	tor	MD 10b. County Wicomic		-	wn or Location Lisbury						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28s)lrec	10e. Street and Number			10f. 7	Zip Code			10g. Citi	izen of What C	ountry?
	eth w	ral	105 Times Square					21804			USA	1.4
920	be filed within 72 hours after deeth with the Maryland tal Hygiene. Ided Hygiene and Thatural', or iteme 23e or 28e-f show event, the Medical Evantine must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:			cedent of H becify Cuba 2∑ No	ispanic Origin? in, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Am Bleck, Whi Specify:	
2-0	72 hor	ted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	168	a. Decedent's U:	work done	during most of w	vorkina	16b. Ki	ind of Business	s/Industry
21215-0036	vithin ne. han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		supply	use retired	1)	•		hospit	+n1
	Hygie Hygie other		17. Father's Name (First, Middle, Last)			Buppin	CICI		ame (First, Middle	e, Maiden		ta.
Maryland		To Be	Samuel Fimple S						e Mattson			
Mar	2 8 8		19a. Informant's Name/Relationship (Robert Manuel/fri						Rural Route Numi le, DE 19	-	r Town, State,	Zip Code)
	Health tem 27 other tr		20a. Method of Disposition		20b. Place	of Disposition (A	lame of	-1	Date	-	ocation - City or	r Town, State
E O	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🕅 Other (Specify		1	ery, crematory o	r other place	1				
Baltimore,	permit. Pages 1 al Department of Hea Important: if Item any injury or othe		21. signature of Funeral Service Licer Ronal of S	Wade Dir	CERT .	The same of the sa		ss of Facility Omy Boar MD 212	gd ₁ 655 W	. Bal	timore	Street
	Physician	من	23a. Pan1. Enter the disease, of com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	ofications that caused the one cause on each line a.	. 18	not enter the m	ode of dyin	g, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as e	consequence	9 of):						
	D #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence	of):						
,092	ate be executed hysician and he burial-transit	cal Examiner	Cause (Disease or injury that infiated events resulting in death) Last	c. Due to (or as a	consequence	→ of):			···			
P.O. Box 68	The law requires that the death certificate to the law seen signed by the attending physicage 2 should be detached for use as the total to the law seen the law s	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal deat	th 3 ⊟Ectopio 5 ⊟ Other				2	23d. Date of de Month	olivery Day Year
	signed by		Part II. Other significant conditions of	ontributing to death but	not resulting	in the underlying	g cause giv	en in Part I.				robably 4 Unknown
Records,	w requires to been signatured should	letec							24a. Wa			utopsy findings available
al Re	ricien: The lav certificate has rector, page 2	Completed by							perl 1 ☐ Yes		death?	completion of cause of
Vital	sicien certif rector	Be	25. Was case reterred to medical examiner?	Hospital:	2 - 2 - ED/6)	DOA Oth		eath (Check only		C - C-	
n of	ng Phys uter this uneral di	on: To	1 Yes 2 No 27. Man or of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	2 ER/C (Year) 28b.	Time of Injury	28c. Injury Wor	y at k?	Home 5 Res 28d. Describe			ecity)
Division of	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	9 280 Place of Injur		M farm, street, fac	_	Yes 2 □ No		(Street and		Rural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier 12 Certifying Pt (Check only one) 2 Medical Exar	nysician: To the best of miner: On the basis of e and manner state	examination a	ge, death occurr und/or investigati	ed at the tin	ne, date and pla pinion, death oc	ice, and due to the courred at the time	e cause(s)	and manner a I place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and mailler 5(d)(29c. Licens	e number		29d. Dat	te signed (Mon	th, Day, Year)
	⊬ ≯ ⊢ ŏ		Nehr) L	7044		ė,	114104	
			30. Name and address of person who	completed cause of de-	ath (Item 23a							
			vel NATERAN		5. Divi	510N SI	ner	51	MISRUM	и	0 218	NY
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	SION SI	ald.					

DHMH 17 Rev 1/2001

Amend item/20a, per Type or Rrint in Blass Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 1

		•	For State Registrar	Co	ertificate of	neaith and Mei Death	Reg. N		35756
			Decedent's Name (First, Middle, Last)				Date of Death Month Da		3. Time of Death
	Physici /Medic		Edwine		Foste	ir M	ovember	-5 2 cuy	
	Examin	er	4a. Facility Name (If not institution, give stre	2 11 11	4b. City, Town, o	r Location of Death	40	c. County of Dea	ıth
H	Funeral		5. Social Security Number 6. Sex	7. Age (b) yrs last birthda	y) If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	9. Bir	thplace (State or Foreign
	Director	ļ	210.47.2017	2□F	Months Days	Hours Min.	Month Oay Year	146 M	HRY LAND
	land		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Jown or	Location				10d. Inside City Limits
	Mary I-f sho	ţō	MD	BA	TIMORE	_			1 Yes 2 No
	ith the Marylan or 28a-f show	Funeral Director	10e. Street and Number		10f. Zip Code	_	10g. C	itizen of What C	A '
	s 23a	ral	2033 E. PREST			21213		U.S.F	
' O	fter de	Fune	11. Marital Status 12.	Was Decedent Ever in U.S. 13 Armed Forces? 1 MYes 2 □ No	./	lispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - Ame Black, Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show he Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗹 No	Specify:		Specify: B	LACK
15-("natu	Completed	15. Decedent's Educati (Specify only highest grade co	on 16a. Dec mpleted) (Gir	cedent's Usual Occup	ation during most of working	16b. h	Kind of Business	/Industry
212	i withir iene. r than	omo	Elementary/Secondary (0-12)		PANS POR		G	DOVERN	MENT
	be filed stat Hygind other avant, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fi	irst, Middle, Maidei	n Sumame)	
yla	should be nd Mental marked o	2	JANSTON M	. FOSTER				RD	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Itam 27 Ia marked other than "natural", or Itams 23a or 28a-f shov other traumatic avant, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type,	DAVANTER 391	illing Address (Street	and Number or Rural Ro			
Ē,	es 1 an of Heal fitam 2 r othar		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place	Date		ocation - City or	Town, State
Baltimore,		1	To Barial 2 Cremation 3 ☐ Remarks 1 ☐ Donation 5 ☐ Other (Specify)	GIREPN M	ININT CREM	MATORY 11-11-1	14 BM	Vimole	MARYLAND
3alt	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee	1000	22. Name and Addres	ss of Facility VAUG	HN C. GI	reene h	NEKAL HM
	40540	-	23a. Part1. Enter the disease, or complicati	ons that caused the death. Do not a	MUS YOK		ATTI MOK	e, Mp	Approximate
	Physician		Immediate Cause (Final	ause on each line.		9, 00011 00 001 000 01 10	opinatory arroot,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	Inju	cy			5 Days
	Examiner		Sequentially list conditions, b.	entricular	- Arrh	ythmia			5 Days
	led sit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	/	1			<i>=</i> 1
,	be executed sician and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence of):	XICATI	ov)			3 stargs
09/89	The law requires that the death certificate be executed to has been signed by the attending physician and sage 2 should be detached for use as the burral-transit	Medical	d						
	ertifica ding pl	/Med	IF FEMALE:	6					
Вох	eath cer attendir for use	Physician/	in the past 12 months?		BEctopic pregnancy			23d. Date of del Month	ivery Day Year
P.O.	by the destached	hys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					
	es that igned b	by P	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ord	w require been si should I						1 ☐ Yes 2	□No 3□Pr	obably 4 Onknown
Vital Records,	has b	Completed					24a. Was an autopsy performed?	24b. Were au prior to death?	stopsy findings available completion of cause of
tal		င္ပ	25. Was case referred to medical			26. Place of Death (C)	1 Yes 2 No		2 No
	nyalcia nis cert direct	To B	examiner? N⊈ Yes 2 No Hosp	ital: 1 X Inpatient 2 - ER/Outpati	ent 3 DOA Cthe			6 Other (Spe	cify)
n of	ding Ph h. After th funeral			8a. Date of Injury (Month, Day Year) 28b. Time Injury	Work		Describe how inju	ry occurred	
Division	at at	lcat	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury - At home, farm, s		Yes 2 □No	Location (Street ar	nd Number or Ri	ıral Route Number,
Ω	al or A s after Il Dire	Certification	4 Homicide	building, etc. (Specify)	on oot, radiory, onloc		City or Town, State	9)	ara riodio ridingoi,
	To tha Hospital or Atta within 24 hours after de To tha Funaral Directo completely filled in by th		29a. Certifier 1 Certifying Physicia (Check only 2 Medical Examiner:	n: To the best of my knowledge, dea On the basis of examination and/or	ath occurred at the tim	ne, date and place, and	due to the cause(s) and manner as	stated.
	To tha h within 24 To tha F complete	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License			te signed (Monti	
•	7 × × ×		pen Pengyat	0				_	
	1		30. Name and address of person who compl	eted cause of death (Item 23a) (Type	e, Print)	,	1 11000	SINDEK	0,004
			Deri Sengupta 6	00 N. WOLFE Sto	reet BA	1000 H:moxe, 1.	ARYLANC	1 212	87
	Sta Registr	- 3	31. Date filed (Month, Day, Year) NOV 1 2 2004	32. Registrar's Signature	Sparks		/		

			1 - For State of Maryland / Department of Health Certificate of Deat			35757
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death
	/Medio Examir			n of Death	4c. County of Dea	
	Funeral		Months Days Hours	er 24 Hrs. 8. Date of Birth Min. Month, Day,	Year) 9. Bir	thplace (State or Foreign
	Director	٥	Usual Residence of Decedent	9-28-	33 M	ryland.
	hours after death with the Maryland urel', or Items 23a or 28a-f show at Examination in the recitibed at	ctor	10a. State 10b. County 10c City, Town or Location Baltimore			10d. Inside City Limits 1 Yes 2 No
	h with the	al Director		11	Og. Citizen of What Co	ountry?
(0	r Items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1. Ves 2 No If Yes, Specify Cuban, Mexic	Origin? (Specify Yes or No- ean, Puerto Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, te, etc.
5-0036	"naturel", o	ed by	Year or Dates:		Specify: B	ACIC
21215	withir sne.	Completed	(Specify only highest grade completed) (Give kind of work done during medical points) Elementary/Secondary (0-12) College (1-4or 5+)	ost of working	Armen	Stool
		Be	17. Father's Name (First, Middle, Last)	ther's Name (First, Middle, M	faiden Sumame)	0,000
Maryland	and and selections	J.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num	ber or Rural Route Number	City or Town, State,	Zip Code)
_	iges 1 and 2 it of Health It item 27 or other tre	,	20a. Method of Disposition 20b. Place of Disposition Name of cometeny, crematory or other place)	Date Date	20c. Location - City or	Town, State
Baltimore	Parit me		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	11.10-04	Baltine ral Serv	rey MS
B	permif. Departr Importa eny inji		Vaugh trune yang work	LOCUL DUV	1.0.4	400
	Pnysician		23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	as cardiac or respiratory arre	ST,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useas 3 or in juy) that initiated events			
8760,	cate be executed physician and the burial-transit					
9	ertificate ding phys	Medical				
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ □ Other (specify) □		23d. Date of del Month	ivery Day Year
<u>α</u>	res that thisigned by	by Phy		t I. 23e. Did tob	acco use contribute to	the cause of death?
Records,	s been si should	ompleted		1 ☐ Ye		obably 4 Unknown Itopsy findings available
al Re		O		autopsy perform	y prior to death?	completion of cause of
of Vital	sir dij	To Be	examiner? Hospital:	ce of Death (Check only one Nursing Home 5 - Resider		cify)
ion c	Attending P r death. ector: After t by the funera	atlon;	27. Manner of Death 28a. Date of Injury Work? 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury M 1 Yes 2	28d. Describe ho	w injury occurred	
Division	iel or Attending Pl s after death. el Director: After tl ed in by the funera	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Ru , State)	ıral Route Number,
	Hospi 4 hour Funer ely fille	edical C		and place, and due to the ca eath occurred at the time, da	use(s) and manner as te and place, and due	stated, to the cause(s)
	To the a within 2. To the complet	Me	CON Circulation and title of confiden	29	d. Date signed (Month	h, Day, Year)
•	\wedge		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7 >0 N	OVEMBE	R 5,2004
	Sta	ta	FALATHIC SHASH DHARAN, 5601 LOC	L Raven Pex	ind. Mi	121239
	Registr		31. Date filed (Month Para Year) Search Search Sports			

			For State Registrar	State of Maryland	d / Department of I			2004	35758
	Physici		1. Decedent's Name (First, Middle, Las.	- Foule	<u> </u>		2. Date of Death Month	Day Year	3. Time of Death
	/Medie Examin Funeral Director		4a. Facility Name (If not institution, give	uare 1105	Pital Ros-		8. Date of Birth (Month, Day, Ye	4c. County of Deat Bo 1+ an 9. Birt	
	Maryland -f show lied al	tor	10a. State 10b. County	10c City	Town or Location				10d. Inside City Limits 1 Yes 2 □ No
	with the	I Director	10e. Street and Number	Circle:	10f. Zip Code	23	10g.	Citizen of What Co	
>+ E	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Ezerjahar i just be nyillied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 11 Yes 2 No If Yes, Give Year or Dates:	6. 13. Was Decedent of No. 12 Yes 22 No.		cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	ncan Indian, e, etc.
√ <i>e</i> 215-0	hin 72 hours s. an "natural; Medical Ex	Completed	15. Decedent's Edd (Specify only highest grad	cation le completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working	16b.	. Kind of Business/	Industry
) 4 July 21	be filed withir ntal Hygiene. od other than event, the M	ø	17. Father's Name (First, Middle, Last)	Osiage (1-401 5+7	Supply	18. Mother's Name	(First, Middle, Maid	Vijit Ien Sumame)	ary
arylar	should and Mer marke	ToB	Sulvesterto 19a. In rmant's Name/Relationship (T)	Wer Se	19b. Mailing Address (Street	May and Number or Rural	Poute Number, City	Rall y or Town, State, Z	(ip Code) 11132
e, ~	1 and Health em 27 ther tr	•	Panelan D 20a. Method of Disposition		4218 St ace of Disposition (Name of metery, crematory or other place	ar Cir	de Ro	Location - City or T	Town, State
	Pag nent ant: I ury o		↑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	A Co	wasyille Ve	terco III	12/04]	Batton	one, MD
- 8	permit. Departr Importa any inji		23a. Part1. Enter the disease, or comp	As Sheller cations that caused the death	49 05 Y	ock Td.	Bath	W 21212	Approximate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Upper G	[Bleed		Toopilatory arrost,		Interval Between Onset and Death
, 1	examiner an and ial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence.	эпсө ођ.				
P.O. Box 6	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as i	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the second of the second control of the second co	death 3 Ectopic pregnancy	/		23d. Date of delive Month	very Day Year
ds, P	uires that signed b Id be deta	d by PI	Part II. Other significant conditions con	ntributing to death but not resul	ting in the underlying cause giv	en in Part I.		1	the cause of death?
Division of Vital Records,	t: The law requir	Completed					24a. Was an autopsy performed?	24b. Ware auto prior to co death?	opsy findings available ompletion of cause of
of Vita	hysi his c	To Be	1 Yes 2 No		R/Outpatient 3□ DOA Oth	4 Nursing Home	e 5 Residence		(fy)
sion	tending I leath. tor: After the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)		Yes 2 □ No	3d. Describe how inj		
Divi	ital or At urs after d ral Direct lled in by	CertIf	4 Homicide determined	building, etc. (Specify)	ne, farm, street, factory, office		8f. Location (Street a City or Town, Sta	ite)	
:	the Hosp nin 24 hou the Fune npletely fi	fedical	one)	sician: To the best of my know ner: On the basis of examination and manner stated.	on and/or investigation, in my of	pinion, death occurred	nd due to the cause(d at the time, date ar	s) and manner as s nd place, and due t	stated. to the cause(s)
	P ∰ P 50	Σ	29b. Signature and title of certifies	reinin	29c. License	£477	29d. D	ate signed (Month,	Day, Year)
	7)		30. Nam an address of person who co	mpleted cause of deam (Item 2	23a) (Type, Print)	eprive	Baltimo	re, MD	21237
	Sta Registra		31. Date (10 / 1 2 2004	32. Registrar's Signatu	Some				

	4	For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H	lealth and l Death	Mental Hy	giene Reg. No	2004	35759
Physicia: /Medica	n	Decedent's Name (First, Middle, Last)	Charles		FRANK		2. Date of De Month Novemb	Day	y Yeer 1, 2004	3. Time of Death
Examine		4a. Facility Name (If not institution, give so 700 Burnt Mills Av			4b. City, Town, or Silve	Location of Deat			County of Dea	th
Funeral Director		051-16-0082	M 2□F 7. Age (In yrs.)		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir	th ly, Year)	9. Bir C	thplece (State or Foreign ountry) York
e Maryland		Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		Town or Lo	cation Spring					10d. Inside City Limits 1 ☐ Yes 2 No
with the or 28	Directo	10e. Street and Number 700 Burnt Mills Av	ronuo		10f. Zip Code	20901			izen of What C ted Sta	
ING 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or items 23s or 28s-f show event, tra Mydical Examinar must be to vitilled at	Dy rur		2. Was Decedent Ever in U. Armed Forces? 1 XYes 2 No if Yes, Give Year or Dates: WW		Was Decedent of H f Yes, specify Cuba		Specify Yes or No to Rican, etc.)		14. Race - Am Black, Whi	erican Indian,
Maryland 21215-0036 d 2 should be filed within 72 hours at the and Mental Hygiene. 77 is marked other then "natural, or traumatic event, tra Medical Erant	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+) 5+	(Give life. l	tent's Usual Occup kind of work done o DO NOT use retired	during most of wo	rking		ind of Business Medicin	
VICE, MARYIANG 2 s 1 and 2 should be filed if Health and Mental Hygi Item 27 is marked other other traumatic event.	o pe c	17. Father's Name (First, Middle, Last)	ouis Frank				me (First, Middle, Ler Parve	Maiden		
		19a Informant's Name/Relationship <i>(Typ</i> Patricia Koslowe, I			g Address (Street a Burnt Mil			-		
Baltimore, Sermit. Pages 1 ar Department of Hea mportant: If Item; any injury or othan		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		moton: area	sition (Name of natory or other plac non Cemet	ery 11/1	Date 4/04		ocation · City or ndale,	
Baltimol permit. Pages Department of Important: If I eny injury or o		21. Signature of June al-Service Unanco		122 To	Name and Address Name and Address	ss of Facility Hebrew	Funeral			20012
Physician /Medical		23a. Part Ener the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line. Alzheimer's Due to (or as a consequ	Diseas		g, such as cardiad	c or respiratory a	rrest,	, ,	Approximate Interval Between Onset and Death 4 Years
8760, cate be executed by physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to limit addate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)							
death certifice attending of for use as	rnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregna 1 □Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year
	à	Part II. Other significant conditions conf	tributing to death but not resu	ilting in the ur	nderlying cause give	en in Part I.		obacco u Yes 2		o the cause of death? robably 4 XUnknown
Vital Records, sician: The law requires t certificate has been signe rector, page 2 should be o	Completed						24a. Was autop perfo 1 \(\text{Yes} \)	osy rmed?	prior to death?	utopsy findings available completion of cause of
Vital I	9	25. Was case referred to medical examiner?	ospital:		t all post Othe	0.00	ath (Check only o	one)		
this all di	non:	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun	4 Nursing F	dome 5 X Resident 28d. Describe to			city)
DIVISION Altenor attendent attendent l'Director: d in by the	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tox			ural Route Number,
To the Hospital within 24 hours a To the Funeral completely filled	edical		icien: To the best of my knower: On the basis of examinal and manner stated.							
To th within To th comp	Me	29b. Signature and title of certifier	ana		29c. License D	o number 0000143			ember 12	•
20		30. N me and address of person who cor Hubert J. Alpert,				230, Sil	ver Spri	ng,	MD 209	910
State Registra		31. Date filed NOW Pay, Zar2004	32 Registrar's Signa		Spark					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day November 10, 2004 /Medical 4a. Fecility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Deeth 9224 Ravenwood Road Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F Director 215-01-8382 95 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-1 show 10d. Inside City Limits marked other than "natural", or Itams 23a or 28a-f shov umatic event, the Medical Examinar is ust be notified at 1 ☐ Yes 2 No Maryland Baltimore Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9224 Ravenwood Road 21237 U.S.A. fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White ð 1 ☐ Yes 2 💢 No Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade Office Clerk Continental Can Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tent: If Item 27 Is marked otl jury or other traumatic even Be Fabiszak Ida Przybylski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Lois Papparotto (daughter) 9208 Nottingwood Road, Baltimore, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department Important: If any injury o *4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 11/13/2004 Baltimore, Maryland 21. Signature of Funeral source Licens 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 4 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** neumonia resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical the 35 use a IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 20 No 3 Probably 4 Unknown Completed 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Vital funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No Certification: To of 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending death. investigation 2 Accident al or Attences after death filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined To the Hospital c within 24 hours af To the Funeral D completely fitted in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) Schendelo D39758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KEVIN Schendel MD 4101 Franklin Sq. Drive, Suite 321, BALTO, MD 2. Registrar's Signature 31. Date filed (Month, 1 2 2004 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.Z U U L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 950 AM NOU. 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BACTIMORE CITY TRANSITION CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral 1**₽**M 2□F Months Days Min Yrs. **Director** UNKNOWN MARYLANLD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other traumatic avant, it a Madical Every at must be notified at 1 Pes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry partment of Health and Mental Hygiene, ordent: if Itam 27 is marked othar than 'injury or other traumatin. ary/Secondary (0-12) College (1-4or 5+) UNKNOWN Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BEVERLY RASER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 841 HANDALLS TOWN, MO Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, 1 Burial 2 Cremation 3 □Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 11-10-04 CREMATORY CATON SUTULE, MID 22. Name and Address of Facility Howall HOME CIBERTY HOUTS TOO CHARTY HOUTS HAVE A LIST ON THE PROPERTY OF THE PROPERTY O Approximate Interval Between Onset and Death Cause (Final cusease or condition resulting in death) Physician Wasting Syn Due to (or as a consequence of): Syndrome /Medical **Examiner** Advanced AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed iver Failure Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical Bleeding GIL the IF FEMALE: NA A 23b. Was decedent pregnant If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 4 Dinknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? necrosis autopsy performed Scalp Severe anemia 2/ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) Informany this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 Natural
2 Accident Injury 5 Pending 1 Yes 2 No investigation within 24 hours after death To tha Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20057892 who completed cause of death (Item 23a) (Type, Print) 21202 MANDEFRO FORREST BALTIMORE CM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 1 2

2004

ledic	an	1 Terrance Farmer Lass	t) - FARMER JI	P.					2. Dai	te of Death WEMBE	\mathbb{R}^{Day} ,	2004	3. Time of Death 3:50 P M
amin		4a. Facility Name (If not institution, give 569 REVOLUTION ST	•			4b. City, Tov HAVRE						ounty of Death ARFORD	
eral ctor		5. Social Security Number 6. Se 119-52-6256 Usual Residence of Decedent	ox 7. Age ZIM 2□F	(In yrs. las	st birthday) Yrs.	If Under 1 Y Months D		Under 24 lours M	vin. (Mo	te of Birth onth, Day,		Cou	place (State or Foreig ntry) IERSEY
med at	ctor	10a. State 10b. County MD HARFORD		10c. City,	Town or Loc	ation	GRAC:	E					10d. Inside City Limit
BELTIN	Directo	10e. Street and Number				10f. Zip Co				10	•	n of What Cou	ntry?
TEMP	erai	569 REVOLUTION ST.	12. Was Decedent E	ver in U.S.	13 W	2107		nic Origin	? (Specify Ye	s or No-	U.S	· A ·	can Indian
event, ine Medical Ener in er must be nutitied at	by Funeral	1 Never Married 21 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No lf Yes, Give Year or Dates:		If	Yes, specify ☐ Yes 2【【	Cuban, N	Mexican, P	uerto Rican,	etc.)		Black, White, pecify:	
Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-		(Give k	ent's Usual O kind of work of OO NOT use n	done durir	n ng most of	working	1	6b. Kind	of Business/In	ndustry
2	Con	11th		<u> </u>	LANI	DSCAPE						NDSCAPI	ING
	Be	17. Father's Name (First, Middle, Last)							Name (First,		laiden Su	ımame)	
other traumatic	2	TERRACE L. FARMER 19a. Informant's Name/Relationship (T)			19b. Mailine	n Address (Si	-		FARMEI		City or Ti	own, State, Zit	n Code)
tran		NORA FARMER/WIFE	ypo,									MD 2107	
othe		20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name of	of	1	Date			tion - City or To	
ıry or o		1 ☑XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify,				METERY		: 11	-13-04	4 CI	NNAM.	INSON.	NJ 08077
any injury or		21. Signature of Funeral Service Licens	9€ 0									HOme P.	
ā d		partara (8											21001
cal		234. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	blications that caused one cause on each line a. Hyperter Due to (or as a	e. nsive	Do not ente	or the mode of	of dying, s	uch as car	diac or respi			een, Mi	Approximate Interval Between Onset and Death
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			State of Maryland / Dep	partment of Health and Me	ental Hygier	m m 1	05760
			1 - Stata Ragistrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Rag.	2004	35763
	Physicia	an	Delores C. Fizer			Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		5 , 2004 4c. County of Dea	1327 M
	LXUIIIII		St. Agnes Hospital	Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bir	thptace (State or Foreign
	Director		216-54-7217 1 M 2 2 55 Yrs. Usual Residence of Decedent		JUNE 4, 1		Virginia
	land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Many Person	tor	PA York Red Lion	1			1 Tes 2 No
	th the	Olrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	ountry?
	ath w	Funeral Director	412 Woodsdale Drive	17356		JSA	
	er de itams	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Armed Forces? 1 □ Yes 2 ☑ No	b. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Am Black, Whi	
5	urs aft	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	nite
5	filed within 72 hours after death with the Maryland Hygiene. Inther than "natural", or itams 23a or 28e-f show ant, the Mazilcal Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working	16b	Kind of Business	/Industry
7	ithin "u	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	9		
7	iled w hygier her th		12 17. Father's Name (First, Middle, Last)	Homemaker 18. Mother's Name (Own Home	
	d be f antal h ced of	o Be				en Sumame)	
<u></u>	shout nd Me mark	은	Ezra Cecil Craft 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Ma	Frances M Iling Address (Street and Number or Rural		y or Town, State,	Zip Code)
M	alth a alth a 27 is		Elmer Fizer - husband 412	Woodsdale Drive, Re	ed Lion, 1	PA 17356	5
กั	es 1 a of He fitam roth		20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cr	position (Name of Damatory or other place)	ite 20c.	Location - City or	Town, State
Ě	Pag ment ant: I		'4 Donation 5 Other (Specify) Meadowri	.dge Mem. Park 11/01		lkridge,	MD
Dallimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural" or itams 23a or 28e-f show any injury or other treumatic evant, the Modical Examinating must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility ary L. Kaufman Fune:	ral Home (Meadowr	idge MP, Inc.
	au z s a		23a. Part1. Enter de disease, or complications that caused the death. Do not e	250 Washington Blvd.	., Elkrid	ge, MD	21075 Approximate
			shock, or heart failure. List only one cause on each line.		rospiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Bilateral Pulmona Due to (or as a consequence of):	ary Embolus			1 hour
	Examiner		Pancreatic Adend	ocarcinoma			l year
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	be executed iician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
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	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		d				
200	death certifica e attending ph d for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1	Ectopic pregnancy		23d. Date of de	
	e deat he att	sicie	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
г Э	hat thid by the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobacc	o use contribute to	the cause of death?
Ď,	The law requires that the te has been signed by th bage 2 should be detache	d by	Metastatic Pancreatic Adenocarcinoma		1 ☐ Yes		robably 4 Unknown
ecords,	w requ	Completed	Status Post Intramedullary Rod Place		24a. Was an		utopsy findings available
ב	The la te has age 2	omp	Status Fost Inclamedaliary Not Flace	merre	autopsy performed	prior to death?	completion of cause of
N I G	ian: Trifical	Φ	25. Was case referred to medical	26. Place of Death	1 Yes 2 □ (Check only one)	No 1 Yes	2010
> ō	hysical nis ce	To B	examiner? 1 Yes 2 No Hospital: Impatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Home	e 5 🗆 Residence	6 □Other (Spe	cify)
5	ing PI		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury 28b. Time Injury	Work?	3d. Describe how in	jury occurred	
SION	ttand death stor: A	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, s	M 1 Yes 2 No	ocation (Street	and Number or P	ural Route Number,
2	after Dirac	Certification:	4 Homicide determined building, etc. (Specify)	Street, factory, office	City or Town, St		arai riodio ivaribor,
	ospita hours inaral y filled		29a. Certifier Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, ar	nd due to the cause	(s) and manner as	stated.
	To the Hospital or Attanding Physician: The law within 24 butus after death, within 24 butus after death, To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2 or	edical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	Zon Con	Σ	29b. Signature and title of certifier	29c. License number D56226		Date signed (Mont	
	10		Muchy 3 Jack or, o		OCIO	ber 29,	2004
			30. Name and address of person who completed cause of death (Item 23a) (Type Michael Sandor Ballo, 900 Caton Ave	<i>'</i>	1229		
	Sta	ite	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	1 M.	±44J		
	Registr	ar	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	mark.			

			For State	State of Maryla	ind / Depa <i>Cei</i>	artment of He tificate of F	ealth and Me Death	ntal Hygier	2004	35764
	Dhyoisi		Registrar 1. Decedent's Name (First, Middle, La	st)			2	Date of Death		3. Time of Death
	Physicia /Medic	al	Horace 4a. Facility Name (If not institution, giv	E.	G (ordon 4b. City, Town, or			4c. County of Death	11:55 P M
	Examin	er	8512 Woodyard R			Clinto		1	Prince Ge	
	Funeral Director		223-36-6400	FD	s. last birthday)	if Under 1 Year Months Days	Hours Min. (Date of Birth (Month, Day, Yes) 19/30/193	ar) 9. Birth Cou 4 Vi	place (State or Foreign ntry) rginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	e Man ta-fah tified	ctor	Maryland Prince (George's C	linton					1 □ Yes 🕺 🔀 💥 o
	th with th	Funeral Director	10e. Street and Number 8512 Woodyard	Road		10f. Zip Code 20735			Citizen of What Cou USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f ahow amy injury or other treumetic avent. It a Modical Exaciliter must be notified at ODGe.	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:	T 2 7 0 -	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🔯 No	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: W	
5-0	"natui	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of working	16b	. Kind of Business/Ir	ndustry
121	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			g Director	-	Insurance	
Maryland 2	ld be filed entat Hyg ked otha ic avent,	To Be C	17. Father's Name (First, Middle, Last Horace R. G				18. Mother's Name (Fanny L.		len Sumame)	
lary	2 shou and M Is mar eumet		19a. Informant's Name/Relationship				nd Number or Rural			
e, N	1 and Health em 27 thar tr		Agnes Gordon /			2 WOODyar sition (Name of natory or other place	d Road Cl		ryland . Location - City or T	20735 own, State
Baltimore,	Pages tment of f tent: If its jury or o		¹XXBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	(y)	Resurrec	tion Cem.	11/11,	/2004 Cli	nton, Mar	yland
Bal	permit Depar Impor any in		21. Signature Funeral Service Lice	last.	6	160 Oxon	s George P. 1 Hill Road	Oxon Hi	eral Home U, M.D. 20	745
	Pnysician /Medical		23a. Vart1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		C CAC		g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death Weeks
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	sequence of):					
VI	acuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	flicate be executed g physician and as the burial-transit	edicai Ex	Tossing in addition 2001	d.	equance or).					
O. Box 68	death cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of predictions of the second s	etal death 3[Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
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I Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of
Vital		Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death			_
of	Phya this	To To	1 ☐ Yes 2XXNo 27. Manner of Death	28a. Date of Injury	ER/Outpatie	nt 3LI DOA	4 L Nursing Hom	e 5 🔀 Residence 3d. Describe how i	e 6 □Other (Spec njury occurred	ify)
ion	nding Fath. e: After e funera	atior	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year on) Injury		(? Yes 2 □ No			
Division	al or Attends after death	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			reet, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai C	29a. Certifier 1 X gertifying P (Check only one) 2 Medical Exa	hysician: To the best of my iminer: On the basis of exam and manner stated.	knowledge, deal sination and/or in	th occurred at the time to the time the time the time to the time	ne, date and place, ar pinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	und un		29c. License			Date signed (Month	
	13	+	1.11.	completed cause of death (i		Print) LiVingpha	and fur	+ WASHIN	somme 8	Imel
	St Regist	ate rar	31. Date filed MOV 1, 2 20(32 Registrar's Si		Spark	,			

			For State Registrar	State of Maryland /	Department of Healt Certificate of Dea	h and Mental Hygier	
	Physici		1. Decedent's Name (First, Middle, Last)	alana Gos	den	2. Date of Death Month November	Day Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give str Baltimore Rehab II ital Extended Care Cer 5. Social Security Number 6. Sex	reet and number)	4b. City, Town, or Locati A 1 + M C inthday) If Under 1 Year I If Un Months Days Hou	der 24 Hrs. 8. Date of Birth	4c. County of Death
	Director		Usual Residence of Decedent	0.0	Yrs.	7-30-	38 PH
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23a or 28e-f show other traumatic event, the Medical Evarinary was be redilled at	tor	10a. State 10b. County Ratima		wn or Location	(10d. Inside City Limits 1 ☐ Yes 2 No
	with the	by Funeral Director	10e. Street and Number	4	10f. Zip Code	10g. (Citizen of What Country?
~	er death	unera	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or No- ican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	72 hours after natural', or Its	d by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Spec	city:	Specify: BIACK
215-(hin 72 h e. an "natu Medica	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion 16a completed) College (1, 4jor,5+)	a. Decedent's Usual Occupation (Give kind of work done during r life. DO NOT use retired)	most of working	Kind of Business/Industry
d 2121	filed with Hygiene. other than	е Соп	17-h CRADE 17. Father's Name (First, Middle, Last)	MA	Car Transp	ORTER other's Name (First, Middle, Maid	Automobile en Sumame)
Maryland	2 should be a nand Mental is marked or raumatic eva	To Be	KROME GOODEN		+6	urriet Johns	$\sigma \mathcal{O}$
	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural; any injury or other traumatic event, the Medical Ext. And.		19a. Informant's Name/Relationship (Type Kyle Gooden (S	(a, Print) 19	b. Mailing Addr ss (Street and Nu	mber or Rural Route Number, City	v or Town, State, Zip Code)
nore	Pages 1 nent of He nt: if itan iry or oth		20a. Method of Disposition 1		of Disposition (Name of ery, crematory or other place)	Date 20c.	Location - City or Town, State
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	2	22. Name and Address of Fa	acility Jaugha CGr	eene functaione.
	40=00		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do	not enter the mode of dying, such	as cardiac or respiratory arrest,	MST0W7UIII) 21133 Approximate Interval Between
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death) a.	PROSTATE C	ANCER WITH	DIFFUSE MET	Oaket and Death
2	Examiner	hu.	Sequentially list conditions. b.	Due to (or as a consequence			
1,1	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):		
8760,	cate be executed physician and the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequence	of):		
9	leath certificat attending phy I for use as thu	/Medi	IF FEMALE:	c. If yes, outcome of pregnancy			
P.O. Box	the c y the achec	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Records, F	iw requires that s been signed b : should be deta	by	Part II. Other significant conditions contr	ibuting to death but not resulting	in the undertying cause given in Pa		ouse contribute to the cause of death? 2 No 3 Probably 4 Unknown
l Reco		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital	Physicien: this certifical	To Be (25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{Y} \) No	spital: 1 ☐ Inpatient 2 ☐ ER/O	Oth	ace of Death Check onlone	
on of	ding Phy I. After this funeral o		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury 28b.	Time of 28c. Injury at Injury Work?	Nursing Home 5 Residence 28d. Describe how inj	
Division	Attander deatlacter:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	M 1 ☐ Yes 2 arm, street, factory, office		and Number or Rural Route Number, te)
_	To tha Hospital or within 24 hours afte To tha Funaral Dir completely filled in	Medical Co	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	f: On the basis of examination at	e, death occurred at the time, date	and place, and due to the cause(death occurred at the time, date at	s) and manner as stated. nd place, and due to the cause(s)
	To tha within 2 To tha comple	Mec	29b. Signature and title of certifier	and manner stated.	29c. License numb	er 29d. D	ate signed (Month, Day, Year)
			30. Name and address of person who com	pleted cause of death (Item 23a)	r J/4	158 NOV	EMBER 9, 2004
	1		AURORA C. TAN	3900 LUCH PA	VEN BOULEVAR	D. BALTIMORE,	MD 21218
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 1 2 2004.	32. Registrar's Signature	5 Sports		

State of Maryland / Department of Health and Mental Hygien 2 1 1 35766 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** novins ARTHA RB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3935 Lothan Road 5. Social Security Number 6. Sex BE MARFORC If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 1 1 F Months Hours Director Nov-20 222-54**-**466 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, the Medical Ever-ther must be notified at Director 1 ☐ Yes 2 No MARYLAND HARFORD 19, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Itams 23g SOAL 21015 . (Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2★ If Yes, Give Year or Dates: 1 Never Married 25 Married 2X No Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7425. HOMEMAKE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental ALBIRT JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAY H. GRIFFED 2935 LOCHARY BRLHIR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 11 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) Air I SMORIAL 400E 21. Sign ture of Funeral Servic Licensee 22. Name and Address of Facility - BEL Pir. 139AHJ EVANS FUNDRAL CHANEL-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical as a consequence of): **Examiner** erroscherori Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attanding Physician: The law requires that the death cartificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No after death. I Diractor: After this certifice d in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 KNo Medical Certification; 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled within 24 hours a TM Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 36246 04 who completed cause of death (Item 23a) (Type, Print) 5601 Lock Raven Blud Ste 208 A Raltimore 31. Date filed (Month, Day, Year) NOV 1 2 2004 32 Registrar's Signature State Registrar

	1 - State Registrar 1. Decedent's Name (First, Middle, La	State of Maryla	-	rtificate of			Reg. No.	104	35767
sician edical	Edward Clin	•				Month Novembe	Day	Year 2004	3. Time of Death 9:30 P
miner	4a. Facility Name (If not institution, giv			4b. City, Town,	or Location of Death		4c. Cou	inty of Death	
•	7959 Telegraph Ro		7	Sever				e Arur	
ral tor	48/-40-3540	M 2□F 7. Age (in yrs	. last birthday, Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day April 4	r, Year)	9. Birth Cou 7 Nort	place (State or Foreig ntry) th Carolin
Ļ	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru		ity, Town or L	ocation					10d. Inside City Limit
Funeral Director	10e. Street and Number	ilde1 50		10f. Zip Code			10g. Citizen	of What Cou	1 □ Yes 2 ⊠ N ntry?
a C	7959 Telegraph R	oad, Lot 47		211	.44		U	SA	
Annual of the control	11. Marital Status 1 Never Married	12. Was Decedent Ever in Amed Forces? 19 1X Yes 2 No If Yes, Give 19 Year or Dates:		Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White, ecify: Wh	
ieted	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	edent's Usual Occu	pation during most of work ed)	ing		f Business/Ir urel S	•
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ck Driver			Gr	avel (
To Be	17. Father's Name (First, Middle, Last Roscoe Gunter)			18. Mother's Nam	e <i>(First, Middl</i> e. e Brooke		name)	
	19a. Informant's Name/Relationship (Carol Gunter/Wife				t and Number or Rur oh Road, L				Code)
	20a. Method of Disposition		Place of Disp	osition (Name of	!			on - City or T	
5	1X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other pla	ace)				
	' 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service) Lice		orge w	a SILLING COL	n Cem. 11/ ess of Facility DC	15/04 L	Adelr	hi, MI	ne. P.A.
o o	Januar In	M00160			ott Avenue			2070	
an cal	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. End St a Due to (or as a conse	age Lui	ng Cancer			rest,		Approximate Interval Between Onset and Death Yr.
al Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consu	rineuce of):	ructive i	Lung Disea	se 			Yrs.
edical	IF FEMALE:	d							
Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnand □ Other (specify) _	cy			Date of delive Month	ery Day Year
þ	Part II. Other significant conditions of	contributing to death but not re	sulting in the t	underlying cause gi	iven in Part I.		bacco use co es 2□No		he cause of death? pably 4 XIUnknow
Completed						24a. Was a autops perform	sy	prior to co death?	psy findings availab mpletion of cause of 2
To Be (25. Was case referred to medical examiner?	Hospital:	7	Ot	26. Place of Deat				
ation: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	4 Nursing Ho	me 5/X Reside 28d. Describe he			у)
Certification:	3 Suicide 6 Could not be determined			reet, factory, office		28f. Location (Si City or Town		mber or Rura	al Route Number,
Medical Certification:	29a. Certifier XXCertifying Pl (Check only one) 2 Medical Example (Check only one)	nysician: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	th occurred at the to extigation, in my	ime, date and place, opinion, death occur	and due to the c ed at the time, d	ause(s) and late and plac	manner as s e, and due to	tated. the cause(s)
W	29b. Signature and title of certifier	Peilly n	20	29c. Licen D547	se number	2		ned (Month. ber 11	Day, Year), 2004
	30. Name and address of person who Allen Reilly, M	D 4805 Ben	son Ave	enue, Bal	timore, M	2122	27		
State gistrar	31. Date filed (Month, Day, Year) NOV 1 2 2004	32. Registrar's Say	nature	Be					

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:30P M November Josephine Marie Gouty /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel North Arundel Hospital 8. Date of Birth (Month, Day Ye Dec. 19, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Year 1915 **Funeral** 1□M 2\(\frac{1}{4}\)F Days Months Hours Ohio Yrs. 88 Director 263-07-3312 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show ?7 is marked othar than "natural", or itams 23a or 28e-f shov treumetic evant. The Moulcal Experiment must be multified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Hanover 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7674 Ridge Chapel Road 21076 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fi Daisy Terry John Emery Gamble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 is i 7674 Ridge Chapel Road, Hanover, MD 21076 Mr. John W. Gouty / son othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ŏ permit. Page Depurtment of Importent: If any njury or once. Chesapeake Cremation Nov. 10,2004 Stevensville, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licensee Mol3571 Second Avenue S.W., Clen Burnie, MD 21061 ancus 23a. Part1. Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocordia **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the death certificate be executed burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23b. Was decedent pregnant in the past 12 plonths?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DSIBA 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1□ Yes 2 10 or Attanding Physician: filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Mann T Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Latural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 T Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 050725 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

Jennifer Riedingar MD 8601 Veterans Huy M. Wersville, MD 21108 NOV 1 2 2004 State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

			riease	Obeta of Mandand				
			1 - For Stete Registrar	State of Maryland		te of Death		2001 00000
_		_	Registrar 1. Decedent's Name (First, Middle, La	net)	Certifica	le oi Dealii	Reg.	No. 2 U U 4 3 5 / 6 9
	Physici	an	. /	C. GOLLAG	1111		Month	Day Year
	/Medic		4a. Facility Name (If not institution, gi			, Town, or Location of Deat	11100	7 2007 / 0:15 P M 4c. County of Death
	Examin	ięr -	STELLA MARIS	S Hospice		Lutherville		BALTIMORE
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last	t birthday) If Under	r 1 Year If Under 24 Hrs	. 8. Date of Birth	9. Birthplace (State or Foreign
	Director		218-96-3361	10M28F 4/	Yrs.	Days Hours Mill.	OCT 16,	1963 Country) 5C
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c City T	Town or Location			10d. Inside City Limits
	sho	ō	100. State 100. SSSINY	a-	-	17.4.25		1 Ves 2 No
	the N	ect	10e. Street and Number	<u>n</u>	10f 7i	o Code	10g	Citizen of What Country?
	with 30 or		2907 ROSA	LIE AVE		LTIMORE p Code 21234	109.	U.S.A.
	n 72 hours after death with the Maryland "neturel", or items 23e or 28e-f show casal Examited - ust be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.		edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
0	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give			to Hican, etc.)	Black, White, etc.
	hours after turel', or ite	d by	3 ☐ Widowed _4 ☐ Divorced	Year or Dates:	1 Yes	20 No Specify:		Specify: WhITE
5	"nett	Completed	15. Decedent's E (Specify only highest gi	ducation 1 ade completed)	16a. Decedent's Usi (Give kind of w	ork done during most of wo	rking 16t	. Kind of Business/Industry
7	filed within 72 Hygiene. Ither then "nel	g E	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	L PROUSSOR	,	INSURANCE CORP.
7 2	Hygir Hygir ther ant,	ပိ	17. Father's Name (First, Middle, Las	NA	V1-		me (First, Middle, Mai	
<u> </u>	ld be ental ked o	To Be	JOHN Lei	sht		ANNA	RA551	2
>	d 2 should th and Men 7 is marke treumatic	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addres			ty or Town, State, Zip Code)
>	and 2 ealth a m 27 is	1	John Leist	t (FATHER)	2907 K	OSALIE AV	e Balto	MO 21234
5	- I 3 =	(i 3)	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Personal from State	e of Disposition (Na etery, crematory or	nme of other place)		. Location - City or Town, State
Ĕ	Pages ment of lent: If It lury or o		'4 Donation 5 Other (Spec	Theilioval Ilolli State	_	metera 11	3/04	SA Ito. MS.
bannore,	permit Pag Depar ment Importent: any injury c	Ì	21. Signature of Funeral Service Lice	nsee	22. Name a	nd Address of Facility	STULA FU	neral Home CHTD.
	<u>v</u> ∪ = ⊴ ⊴		faul Ill.	- Julia	17527	harford 20	· 130 ito.1	
			23a. Pav 1. Enter the disease, or construct, or heart failure. List only	one cause on each line.	Do not enter the mo	de of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a END STAGE RE		SE		
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-		ical		⊾ d				
9	leath certificate attending phy I for use as the	by Physician/Med	IF FEMALE:					
Ž Q	ath ce ttendi or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	ath 3 □Ectopic p			23d. Date of delivery Month Day Year
5	at the dea by the a stached fo	sic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	h 5 ☐ Other (s	pecify)		Mondi Buy Four
7.	The law requires that the death the has been signed by the atter bage 2 should be detached for u	Ph	Part II. Other significant conditions	contributing to death but not resulting	na in the underlying	cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
Records,	w requires that been signed b should be deta				, ,	•	1 ☐ Yes	
Ö	w req been shou	Completed					24a. Was an	24b. Were autopsy findings available
ě L	he lay e has	Ę.					autopsy performed	prior to completion of cause of death?
		0	25. Was case referred to medical			26 Place of De	1 ☐ Yes 2 🛣	No 1 Yes 2 No
	Phyeiclen: this certific ral director,	0	examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3 □ D	Othor	dome 5 Residence	6 ▼ Other (Specify) HOSPICE
	0 0	h: T	27. Manner of Death	No.		28c. Injury at Work?	28d. Describe how in	ZE HOULTON
0	Attending F r death. ector: After by the funera	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	on	M	1 ☐ Yes 2 ☐ No		
DIVISION	r Atte	Certification:	3 Suicide 6 Could not 4 Homicide determined		, farm, street, factor	y, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)
2	ne Hospitel or Attendin 124 hours after death. 1e Funerel Director: Af bletely filled in by the fur							
	Hosp 24 hou Fune Telly fi	Medical	(Check only 2 Medicel Exe	hysicien: To the best of my knowle miner: On the basis of examination	edge, death occurred a and/or investigation	d at the time, date and place n, in my opinion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the Hos within 24 ho To the Func completely f	Mec	29b. Signature and title of certifier	and manner stated.	29	c. License number	29d.	Date signed (Month, Day, Year)
	F 3 F ŏ		1-			Durn	(-	11/10/04
	2	-	30. Name and address of person who	completed cause of death (Item 20	Ba) (Type, Print)	- 1312	7	11/1-/-1
	a		DR. TARIQ MAH			RD. TIMONTI	JM,MD 2109	3
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Θ			
	Registr	rar	NOV 1 2 2004	Brown & A	TABLE!			

DHMH 17 Rev 1/2001

10:15 p.m.

NOVEMBER 9, 2004

KAREN GOLLADAY

			For State Registrar	State of Maryland		artment o				2004	35770
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) Elizabeth	Gregory		45 65 7		Λ	Date of Death Month Wember	Day Year 7 2004	3. Time of Death 445P M
	Examin Funeral	er	4a. Facility Name (If not institution, give s 5. Social Security Number 6. Sex	ge	st birthday)	SV/	Cesu rear If U	nder 24 Hrs.	3. Date of Birth	4c. County of Death	place (State or Foreign
	Director		215-16-2090 Usual Residence of Decedent 10a. State 10b. County	XX 83	Yrs.		ays Ho	urs Min.	May 15,	1921 Mary	/land
	the Maryla 28a-f shov	ector	Maryland Carroll 10e. Street and Number		/kesvi		ode.		100	g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
	h with	af Di	710 Obrecht Road			· ·	1784			USA	,
396	be tiled within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or tiems 23a or 28a-f show event, the Medical Estrict must be notified.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decedent If Yes, specify		ic Origin? (Spec exican, Puerto R ecify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify:	
2-0	72 hou nature	eted	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual C	Occupation	most of working	16	6b. Kind of Business/li	ndustry
21215-0036	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use 1 counta:				Automobi	10
	e filed al Hygid I other vent, t	Be Co	17. Father's Name (First, Middle, Last)		710	Courrou			First, Middle, Ma		10
Maryland	should be nd Mental marked o	인	Francis Patrick St		10h Mailin	- Add (C		Laura		City or Town, State, Zi	- C- d-)
	alth a		Camilla Kinsley	Sister					aryland		b Code)
Baltimore,	0 0		20a. Method of Disposition X1X Burial 2 □ Cremation 3 □ R '4y□ Donation 5 □ Other (Specify)	omoval from State	metery, crer	esition (Name matory or other Ige Cem	r place)	11/11/0		oc. Location - City or T	
Balti	permit. Pages Department of Important: If it any injury or once.		21 lignature of Funeral Service License	in Knocker	22	2. Name and A				efeld Funeral more, Maryla	
	Pnysician /Medical		23a. Part1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line. Due to (or as a consequence)	10	dem dem	of dying, suc	th as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Examiner	<u>_</u>	Sequentially list conditions,	. — Due to (or as a conseque	ance of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Energy to cause (Disease or injury that initiated events		ence on.						
8760,	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):						
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 21 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	déath 3[]Ectopic pregr] Other (speci				23d. Date of delive	ery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	tributing to death but not result			se given in 1 hy 10	Part I. Didism	23e. Did toba 1 ☐ Yes	cco usa contribute to	the cause of death?
Vital Records,		Completed	anemia, oster	oporosis			/		24a. Was an autopsy performe 1 Yes 2	prior to co	opsy findings available ompletion of cause of 2 No
	Phyaician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3□ DOA	04		Check only one	ce 6 Other (Speci	4.)
n of	ding Phy h. After this funeral o	\vdash	27. Manner of Death 1. Natural 5 Pending		28b. Time of Injury		Injury at Work?		d. Describe how		197
Division	death death ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon		M reet, factory, or	1 🗀 Yes		f. Location (Stre	et and Number or Rur	al Route Number,
á	ital or . irs after ral Dire	Certi	4 Homicide	building, etc. (Specify)					City or Town,	State)	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examination)	sician: To the best of my knowner: On the basis of examination and manner stated.		vestigation, in	my opinion	. death occurred	d at the time, date	e and place, and due t	o the cause(s)
	Q, 2 kit 1	-	29b. Signature and title of certifier	(pleel no			icense num	59943		d. Date signed (Month,	
•	10		30. Name and address of person who co		23а) (Туре,	Deina			- 307	overniser westmins	per MD,
	s Sta	ate	31. Date filed (Month, Day, Year)	82. Registrar's Signatu	<u> </u>	porks	MVE	. > 1	- 201		21137.
	Registi		NOV 1 2 2004	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	1	yours					

			For State Registrar	State of Marylan		rtment of Healt		ygiene 004	35771
ı	Physici /Medio		1. Decedent's Name (First, Middle, La EDWAR	3) C. G		ASON	2. Date of D Month		ar 11,60 M
	Examin		4a. Facility Name (If not institution, gives	1/1- 11	5E	4b. City, Town, or Location BALT If Under 1 Year If Un	MORE	4c. County of D	4
ł	Funeral Director		2/5-24-5146 Usual Residence of Decedent	1×M 2□F 76	Yrs.		der 24 Hrs. 8. Date of E	Day, Year) 1928	Birthplace (State or Foreign Country) MD ,
	h the Maryland r 28a-f show anotified at	Director	10a. State 10b. County	A B.	y, Town or Loc	MORE			10d. Inside City Limits 1 Yes 2 □ No
	eath with the 23a or 2	eral Dire	10e. Street and Number 5009 11. Marital Status	4 DK FORD	AVE	10f. Zip Code 2/20	6	10g. Citizen of What	Country?
5-0036	n 72 hours after death with the Maryland "natural", or Itame 23a or 28a-f show suital Examinat must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	Yes, specify Cuban, Mex	Origin? (Specify Yes or Nican, Puerto Rican, etc.) cify:	Black, W	thite, etc.
0-CLZ1	within 72 ho ene. than "natur ha Medical	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give I	ent's Usual Occupation kind of work done during in ONOT use retired)	most of working	16b. Kind of Busine	ess/Industry
and 2	be filed Ital Hygi Id other	To Be Co	17. Father's Name (First, Middle, Last	GLEASON)		Other's Name (First, Middle NDA LO		PACI DRING
, Mary	and 2 should ealth and Mer n 27 le marke ler traumatic	-	19a. Informant's Name/Relationship (1		mber or Rural Route Num	ber, City or Town, State	e, Zip Code) MD . 21225
Baltimore,	Pages 1 nent of Hu ant: If itan ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	Jinemovar moni State	lace of Disposemetery, arem	eition (Name of atory or other place)	Nov. 1	20c. Location - City BALTE	or Town, State
Dail Dail	permit. Pag Department Important: any injury c		21. Signature of Ameral Service Line	Apardo	h. á	Name and Address of Fa	SOUST.	D. WRZYY SKARDA	FH.
* }	Physician /Medical		23a. Part 1. Enter the disease, or for shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Due to (or as a consequence)	Il fail	USE	as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ					,
og,	be executed sician and burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	uence of):				
0X 68/6U	that the death certificate be executed ed by the attending physician and detached for use as the burial-transii	//Medical	IF FEMALE: 23b. Was decedent pregnant	d	incy			23d. Date of	delivery
7.0. Box	the ache	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		Ectopic pregnancy Other (specify)		Month	Day Year
Records, 1	tw requires that the s been signed by th should be detache	þ	Part II. Other significant conditions of Chronic	contributing to death but not result to the public				N	e to the cause of death? Probably 4 □Unknown
аі кес	a taw has b e 2 si	Completed						s an 24b. Were prior 1 death 2 No 1 Y	
or vital	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director After this certificate completely tilled in by the tuneral director, pag	n; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient	Othor	lace of Death (Check only Nursing Home 5 Res 28d. Describe		pecity) Hospice
UNISION	r Attending er death. ractor: Aft	ertification;	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	n 290 Place of Injury. At he	Injury ome, farm, stre	M 1 Tes 2	28f. Location	(Street and Number or own, State)	Rural Route Number,
2	Hospital o	edical Cer	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my knominer: On the basis of examinat	wledge, death	occurred at the time, date	and place, and due to the death occurred at the time	e cause(s) and manner of date and place, and d	as stated. lue to the cause(s)
)	To the within To the comple	Med	29b. Signature and title of certifier	A MP		29c. License numb		29d. Date signed (Mo	1
	W		30. Name and address of person who		5.4	Print)	^	1014	
Ş	Sta Registr	w	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	Sporks		<u> </u>	

10-30-04 011 Pm

			1 - For State Registrar	State of Marylar		artment of H			ene	05===
		10	Decedent's Name (First, Middle, Las	")				2. Date of Death	MAT O O	3. Time of Death 2
н	Physici /Medio		James Edward	Girvin, Jr.				Month 1/VVCm	Day Yes	00 4 05158 AM
	Examin		4a. Facility Name (If not institution, give		480-	4b. City, Town, or	Location of Dea	th	4c. County of D	eath
			1506 Old Mountai			Joppa			Har	ford
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day, Y	'ear) 9.1	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		66 TIS.			July 15,	1938 M	Maryland
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. fnside City Limits
	a-f st	ctor	Maryland Harford		Joppa					1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?
	ath w		1506 Old Mounta			210			USA	
	ltems	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - A Bfack, W	merican Indian, hite, etc.
36	Irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 25万 No ff Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or tiems 23a or 28a-f show event, I're Medical Examinat must be notified at		15. Decedent's Ed	cation	16a. Dece	dent's Usuaf Occupa	ation	16	b. Kind of Busine	White ss/Industry
215	ithin 7 ne. nan "n	Completed	(Specify only highest grad	(a completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	luring most of wo)	orking		,
2	filed wii Hygien other th	Соп	12		Owne:	r/Operato	r		Truck Dr	iver
pu	be filed ital Hygi of other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
Ŋ	2 should be f and Mental H is marked ot raumatic ever	To	James Edward 19a. Informant's Name/Relationship (7)					a Mildred		
Maryland	d 2 sł th and th and traun		Dorothy Girvin					ural Route Number, C		
	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	tain Roa	ad, Jopa,	Mary Lan c. Location - City	
Baltimore,	Pages nent of l int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Tellioval Holli State						
ij	그 든 뿐 글		21. Sign world Full and Service Licen) De	22 ALL 1	Name and Addres	s of Facility	1-13-04 Iome, P.A.	sel Air,	Maryland
m	Department Department			4	Ī	lCComas Fi 1317 Coke	uneral F sburv Ro	Home, P.A. Dad. Abing	don. Mar	yland 21009
			23a. Part. Enter the disease, or comp	ications that caused the dea	th. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	11.	ance					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec						- Omorro
П	LAdililiei	_	Sequentially list conditions,	b	NO CONTRACTOR OF THE PARTY					
	ted	nine	Sequentially list conditions, Tarry, Joanny to minimaliate cause. Enter Underlying Cause (Disease or injury	Due to (or se a concex	quanea ory:					
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d						
ပ	tificat ng phy as th	Medi	To see the see that the see tha					_		
Вох	eath certific attending p for use as	Physician/Me	230. Was decedent pregnant	23c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of d	
0.	he dea	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o		Other (specify)			Month	Day Year
Ρ.	that the de ad by the detached	Phy	Part II. Other significant conditions co	of shuting to death but not rec	sulting in the ur	dorhing course success	n in Dort I	220 Did tobas	non una anntaibuta	to the cause of death?
Records,	signed d be det	d by	Tall III of the organization of the organizati	mindaling to doubt but not 163	saking in the di	idenying cause give	IIIII: Faziți.	12 Yes		Probably 4 Unknown
Sor	w requir been si should	lete								
Re	The lav	Completed						24a. Was an autopsy performed	prior to	autopsy findings available o completion of cause of ?
Ita		Ö	25. Was case referred to medical				26 Place of Do	performed 1 Yes 2	No 1 □ Ye	es 2 No
>	Physician: this certific al director,	O B	examiner?	lospital:	ER/Outpatien	t 3□ DOA Othe			e 6 □Other (Sp	necify)
0	ding Ph	n: T	27. Magner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how		Cony
Sio	uttendir death. ctor: Al y the fu	catle	2 Accident investigation		,,		es 2□No			
Division of	after d after d Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h- building, etc. (Special	ome, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number or i	Rural Route Number,
	pital ours a eral E		29a. Certifier 1 Certifying Phy	dising. To the best of my line						
	a Hos 24 hc Fun etely	edical	(Check only one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my op	e, date and place inion, death occu	e, and due to the caus irred at the time, date	e(s) and manner and place, and di	as stated. Je to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Mo	nth, Day, Year)
			VH Frenha	7,		DIE	314	1/.	ven ho.	(1) 2 7211
	3		30. Name and address of person who co	empleted cause of death (fter	m 23a) (Type, I	Print)	11-7-	NO	-	1/2
			IT rankas, MA	Seasons	1/1/27	Thomas C	hosape	Ni Me ffes	Pice, E	KB4, MD
	Stat		31. Date filed (Month, Day, Year) NOV 1 2 2	32. Registrar's Signa	ature A	Ann	61	/-		
	Registra	ell .	MAKTES	JU4		Laber and	-			

				partment of Health and Mental Hygi Partificate of Death	iene _{og. No.} 2004 35773
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year
	/Medic Examin	al.	Grace Marilyn Grayson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Examin	ei	Harford Memorial Hospital	Havre de Grace	Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min. (Month, Day,	Year) 9. Birthplace (State or Foreign Country)
	Director		219-40-9490 1 M 26 F 61 Yrs. Usuat Residence of Decedent	Oct. 12,	1943 Maryland
	ryland how		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	ith the Marylar or 28a-f ahow	Funeral Director	Maryland Harford Churchy		1 ☐ Yes Ž∏No
	with the	Dire	10e. Street and Number 1222 Glenview Court		Og. Citizen of What Country?
	death ms 23	eral		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian,
	or ite		Armed Forces? 1 ☐ Never Married 2 🕅 Married Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:	Black, White, etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f ahow ent, the Madical Examinar must be multified at	d by	3 Widowed 4 Divorced Year or Dates:		Specify: White
5	in 72 n "nal	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation 1 e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
2121	d with giene er tha	Com	Elementary/Secondary (0-12) Colfege (1-4or 5+) 1 Custo	mer Service Representative	Gas & Electric Co.
Maryland	should be filed within and Mental Hygiene. is marked other than aumatic event, Ira M.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	
- 18	hould d Mer marke matic	၉	George Joseph Ryskewich 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Edith Grace ling Address (Street and Number or Rural Route Number,	Knight City of Town State Zin Code)
Za	nd 2 s lith an 27 ia i			Glenview Court, Churchvil	
J.	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item once.	1	20a. Method of Disposition 20b. Place of Disposition cemetery, cre	position (Name of Date 2 amatory or other place)	20c. Location - City or Town, State
altimore,	Page ment ant: If		'4 Donation 5 Other (Specify) Highview	Mem. Gardens 11-9-04	Fallston, Maryland
Ball	permit. Depart import any inj			22. Name and Address of Facility McComas Fu	
	20:200		23a. Part1. Enter the disease, of complications that caused the death. Do not en	317 Cokesbury Road, Abingd	
	Pnysician	5 1	shock, or heart failure. List only one cause on each line.	ocardial infarc	TION Conset and Death
	/Medical	ľ	Due to (or as a consequence of)		1100 112
	Examiner		Sequentially list conditions, b. hyperter	4510N	yrs
42	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last c. Due to (or as a consequence of):		
8760,	ate be ex hysician the buria		d		
9	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medical	IF FEMALE:		
Вох	attenc for us	cian/	III the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
P.O.	uires that the de signed by the a ld be detached f	hysl	1 Yes 2 No 9 Unknown		
	es tha gned l be det	by P	Part If. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did toba	acco use contribute to the cause of death?
Division of Vital Records,	w requir been si should			1 Tes	s 2 No 3 Probably 4 Unknown
ြို့	ne law has b	Completed		24a. Was an autopsy perform	prior to completion of cause of
a	sician: The lav certificate has rector, page 2	e Co	25. Was case referred to medical	1 Yes 2	No 1 Yes 2 No
Ž	ysicia is cert directe	To B	examiner? 1 Yes 2 No	26. Place of Death (Check only one ont 3 DOA Other: 4 Nursing Home 5 Resider	
n 0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time (Month, Day Year) Injury		
8.0	tendii Jeath. tor: A the fu	catle	2 Accident investigation	M 1 Yes 2 No	
Dİ	i or Attendi after death. Director: A	Certification:	4 Homicide determined determined building, etc. (Specify)	treet, factory, office 281. Location (Stre	eet and Number or Rural Route Number, State)
	ospita hours ineral y filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to the car	use(s) and manner as stated.
	To the Hospital or Attending Physician: The lawintin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	dedical	(Check only 2 Medical Examiner On the basis of examination and/or in one) and manner stated.		
	To To con	Σ	290. Signature and title of dertifier	29c. License number 29	d. Date signed (Month, Day, Year)
	σ_{\prime}		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	7 7
	\		Robert A Duran MD 615W.	MACPHAIL Rd Belmin	2 MD 21014
	Sta		31. Date filed (Month, Day, Year) NOV 1 2 2004 32. Registrar's Signature	5 Sporks	
	Registr	ar	NOV 1 2 2004 Denut		

Gence Ganyson

State of Maryland / Department of Health and Mental Hygiene 2004 35774 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Leonhardt Hutchinson November 2004 7:30 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Vantage House Columbia Howard If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) DEC 2, 190 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min 94 155-30-5366 Yrs. Director Pennsylvania Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b County or 28a-f show traumatic event, the Medical Exercises must be notified at 1 Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code Itams 23a 3905 Mac Alpine Road 21042 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other
any injury or other traum-" 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Philip Leonhardt Eva Strup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Mac Alpine Road Ellicott City, MD 21042 William E. Hutchinson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) * 4 ☐ Donation Metro Crematory, Inc. 11/10/04 Baltimore, MD 21. Signature of Funeral Service Licensee Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Cremation Society of MD, In 299 Frederick Road Baltimon 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Due to (of all a consequence of) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed funeral director, page 2 should be detached for use as the burial-transit and Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Wes decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 Ø No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Honknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 3☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. • Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 413 Com 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene, = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Clarence John Herr, Jr. November 1 717 P /Medical 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore n/a Harbor Hospital Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F 65 Director 212-36-3057 Aug 25, 1939 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. Count in than "neturel", or Items 23e or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Maryland n/a Baltimore 1XYes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1821 Wilhelm Street 21223 r death United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inforciant: If item 27 is marked other than "neturel", or Ital Important: If item 27 is marked other than "neturel", or Ital any jijury or other treumatic event, the Madical Examina 2018. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√2 No þ Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Shipping Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Herr unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia L. Parson - daughter P.O. Box 971, Buxton, North Carolina 27920 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 11/6/2004 Crest Lawn Gardens 21. Signature of Funeral Service Licens to 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASCVD 2 Cardiac Arrythmias one hour /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760. physician Physician/Medical the as ding IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 [] No Division of Vital 2 🔀 No 1 🗆 Yes r: After this certifica e funeral director, § Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tes 2**X** No 1 Inpatient 3□ DOA 2 X ER/Outpatient 27. Manner of Death 28c. Injury at Work? To the Hospitel or Attending Protin 24 hours after death.

To the Funerel Director: After the completely filled in by the funera 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58877 November 10, 2004 eni 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 South Hanover Street, Paltimore 21225 Terri Holmes MD HHC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 1 2 2004

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36	filed within 72 hours after death with the Maryland Hygiene. that then "natural", or Items 23e or 28e-f show ant, the Madical Everyladin institle incillad at		1 ☐ Never Married 2 ☐ Marri 3 🏿 Widowed 4 ☐ Divorced	ied 1 Yes	2 □ No		1 ☐ Yes 2		Specify:	, i dello	riicari, otc.,		city: whi	
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Maryland 21215-0036	should be and Mental a markad o umatic ava	ToE	Monroe Haynes								e Fishe			
ă N	and 2 sh ealth and n 27 is m	111	19a. Informant's Name/Relations Marjorie Haynes								, MD 211		vn, State, Zip	o Code)
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Division of	al or Attendi after death. I Diractor: A d in by the fu	ertification;	2 Accident investig 3 Suicide 6 Could in 4 Homicide determine	not be 28e. Place of	of Injury - At hom g, etc. (Specify)	ne, farm, stre	eet, factory,	office		2	28f. Location (St City or Town		nber or Rura	il Route Number,
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			30. Name and address of person	who completed cause	of death (Item §	23a) (Tvpe 1	Print)	271	(0)	. \	1	11810	,4	
-			1600 Crain	Hoy S	6	Jan 1	Keirs	ger	7	S).				
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State of Maryland / Department of Health and Mental Hygiene 35777 Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last, 2. Date of Deeth 3. Time of Death Month ober 29, 2004 **Physician** tman 7:00 PW /Medical 4a. Fecility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Kolana B. Date of Birth (Month, Dey, Year) Feb 5, 1919 If Under 1 Year If Under 24 Hrs Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months 1□ M 20/F Hours Yrs 148-03-3118 85 Director Massachusetts Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Madical Examinar must be notified at MD Director Baltimore 1 Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 830 W. 40th Street 21211 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours aftar. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or ther any injury or other traumatic event. The Madical Ferren 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) sociologist health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Max Shuman Fannie Pearlmutter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14960 Collier Blvd #4100 Naples, FL 34119 Roy Hartman/step son 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, cremetory or other plece 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Densee Ronald S Wade, Baltimore, MD 21201 is that cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ise or each line. Enter the disease, of complications to or heart failure. List only one cause Approximate Interval Between Onset end Death Physician /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner physician and as the bunal-transit or Attanding Physician: Tha law requires that tha death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es consequence of Division of Vital Records, P.O. Box 68760, Physician/Medicai a consequence of): attending p esn signed by the a Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was en eutopsy paga 2 s No 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this uneral 28a. Dete of Injury (Month, Dey Yeer) 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred After n 24 hours after daath.
ha Funerai Diractor: Aft Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completaly fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 3333 WaL 31. Date filed (Month, Day, Year) 32, Registrar's Signature State NOV 1 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 0535 osephine 07 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Med: ca) WD 2: ca) SysTem
7. Age (In yrs. last birthday) MD University
5. Social Security Number 13 altimor 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 ☐ M 2 🏲 F 218 46 9795 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show traumatic event, the Medical Exemitrar must be notified at 1 Yes 2 No Director tim ove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 renue Itams 23a death Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
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Department of H
Important: If its
any injury or ot 1 Burial 2 Cremation 3 P
1 Donation 5 Other (Specify) 3 Removal from State /o L 21. Signature of Funeral Service Licensee 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** netastatic concer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 TYes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 Z +10 within 24 hours after death.

To the Funaral Diractor: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ro tha Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

. State Registrar

State 31. Date filed (Month, Day, Year) Strar NOV 1 2 2004

Mohan

32. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

& Spark

0047618

11-11-04

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day **Physician** 9:00 p M 8 2004 Hines November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1006 Glenvilla Drive Anne Arundel Glen Burnie 8. Date of Birth (Month, Day, Year)
Mar. 21,1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F 79 Yrs Virginia Director 579-22-8493 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other then "neturel", or items 23a or 28a-f show treumatic event, the Nedicul Erar it at most be notified at 1 ☐ Yes 2 ☐ No MD Glen Burnie Anne Arundel Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 1006 Glenvilla Drive 21061 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: Specify: White þ 3 ◯Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "ne eny injury or other treumatic event, the Medic once. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Executive Secretary U.S. Navy Research 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Catherine Smith William C. Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 166 Peninsula Drive, Lunenberg, MA 01462 Kate Samuels (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Maryland Vet. Cem. 11/12/2004 Crownsville, MD 21. Signature of Funeral Service Litensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mc cordu **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine Vit certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy requires that the death Month Year ō in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) been signed by the a 1 ☐ Yes 2 ₽No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No The law page 2 s certificate 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No Certification: To this Atter this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident tilled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific e of death (Item 23a) (Type, Print) 30. Name and address of person who completed (3) 31. Date filed (Month B 32. Registrar's Signature State Registra

04-7263 B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 ERNESTINE HARPER ER For 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** RNESTINE HORDER 10, 2004 12:08P ^M NOV. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death **Examiner** ST.JOSEPH HOSPITAL TOWSON BALTIMORE Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□M 200 F Hours Months Days 070-26-2449 Usual Residence of Decedent 02 Yrs Director 10c. City, Town or Location 10d. Inside City Limitar 10a. State 10b. Count in than "natural", or Items 23a or 28a-f show the Medical Examinational be notified at 1 ☐ Yes 2 W No Baltimore Funeral Director WID 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number budhriy 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 Married 1 ☐ Never Married 1 Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-40(5+) entary/Secondary (0-12) GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finand Menfall Fig. 18 markad of Klijah Lorena Sharon Ha mmrmant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kandalistown, MD 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of ^ 4 □ Donation 5 □ Other (Specify) 22. Name and address of Ecility Ruynin C. Greene-Fine 8728 Liberty Rd. Randallotown MD 21. Signature of Funeral Service Licensee Greene- Funeral 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear deliure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Complications of right internal-jugular catheter placement Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed atfending physician and for use as the burial-transif that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by fhe a detached f P.O. 9 Unknown signed by fig be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à dialys? (on disease 1 Yes 2 No 3 Probably 4 Unknown Completed peen cardiovascular disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No 24a. Was an cate has b autopsy performed 1 Yes 2 🗆 No certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 【▼ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred Perforation of visto 28a. Date of Injury (Month, Day Year) 28b. Time of Intury 27. Manner of Death After brachio Cephalic vein during therapetic procedure 281. Location (Street and Number or Rural Route Tumber, City or Town, State) 2405 York Rand Natural 5 Pending 10:50 A M 1 ☐ Yes 2 No death. investigation 2 Accident 11-10-04 Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) building, etc. (Specify) Diamis Access specialist Stellow Time nium and stated.

1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. filled in by York Rond hours affer 4 Homicide within 24 hours a 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E 11, 2004 NOV. w. 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) LING. , MID LI 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

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	Examin	er	4a. Facility Name (If not institution, g Chesapeake 1	give street and number) Hospice House			r Location of Death		4c. County of Dea	
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Maryland 21215-0036	h and h and 7 is m		19a. Informant's Name/Relationship Mary Hensley (-			City or Town, State, $1 { m and} \ 2075$	
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Baltimore,	permit, rages Department of h important: if ite any injury or of		21. Signature of Puneral Service Li	121 /					l Home, IN Road Clint	Nc. con, MD 20735
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P.O. 1	ad by the a	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5L	Other (specify)				
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Sec	hasbe	Completed	Hyperlipider		* .			24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings available completion of cause of
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1	to the nospital or Attanunity ritysticant: within 24 hours after death. To tha Funarel Director: After this certified completely filled in by the funeral director, to	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my xaminer: On the basis of examiner stated.	knowledge, deat mination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
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	Physicia	an	1. Decedent's Name (First, Middle, L					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al .		nleen Hartung		4h City Town o	r Location of Death	Nov 8,	2004 4c. County of Death	10:30 A ^M
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	uneral irector		578 26 5711	Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Oct 11,	9. Birth 1924 Mary	place (State or Foreign ptry) Land
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vith th	a or 28 De no	Director	10e. Street and Number	· Ch		10f. Zip Code 20748)		D. Citizen of What Cou	-
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Baltimore, permit. Pages 1 ar	imports any inju		21. Signature of Funeral Service Lice May E Hodging	ensee	22	. Name and Addres	ss of Facility Lee	Funeral	Home,Inc	6633 Old
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Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	been signed by the attendin should be detached for use	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
Division of Vital Records, P.O. for Attending Physician: The law requires that the dating death.	n signed b	d by Pr	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		cco use contribute to the	
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	10		30. Name and address of person who		n 23a) (Type,	Print)	2.4	0		/
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State of Maryland / Department of Health and Mental Hygiene 2004 35783 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Dav **Physician** Robert Lee Harding November 11:46 A M 2004 3, /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Laurel Regional Hospital Laurel Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 214-28-2724 Director 73 Yrs. 6 1931 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits irel, or Items 23a or 28a-f show Examiner must be inclified at Completed by Funeral Director 1XXYes 2 □ No Prince George's Laurel 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 335 Gorman Avenue 20707 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Sheet Metal Worker Construction 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William L. Harding Violet Souder 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Item 27 i Patricia A. Harding/Sister 9267 Old Scaggsville Road, Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State I I 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny Injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk | 11/6/2004 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Thrombosis Minutes /Medical Due to (or as a consequence of): Examiner Metastatic Carcinoma Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (us as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Bronchogenic Carcinoma Due to (or as a consequence of): Box 68760 physician by Physician/Medical the USB as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2/ZXN0 2XXN0 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ¥No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred After s after dec. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) November 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William A. Warren, 321 Prince George Street, Laurel, MD 20707 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Yeer Αм /Medical Andrew L. Hoh November 9, 2004 10:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Slade Manor Assisted Living Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**X**M 2□ F Hours 87 Yrs. Director 216-03-3506 Mar 10, 1917 Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, It e Medical Examiner must be notified at 10d, Inside City Limits Director 1 ☐ Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7503 Park Heights Avenue 21209 by Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify:
White 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ges 1 and 2 should be filed within t of Health and Mental Hygiene. If frem 27 Is marked other than ' General Motors Elementary/Secondary (0-12) College (1-4or 5+) 8 Assembly Line Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Piper Raymond Frances Hoh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Weinstein/Daughter 2137 C. Woodbox Lane, Baltimore, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State parmit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Nov 10 * 4 ☐ Donation '5 ☐ Other (Specify) Chesapeake Crematory 2004 Beltsville, MD 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee MO0986 ule 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death CONGESTIVE HEART FAILURE Priysician SEVERE /Medical CARDIOVASLULAR Due to (or as a consequence of): **Examiner** BILTERIOSCLEROM DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-transit LORT Due to (or as a consequence of): Box 68760, physician Physician/Medicai the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by BRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 25 No Division of Vital 1 Yes the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner's Hospital: 1 Inpatient SSISTE Other: 4 Nursing Home 5 Residence ပ 1 🗌 Yes No. 2 ER/Outpatient 3 DOA 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Lath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury Natural 2 Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 32. Registrar's Signature 2121 31. Date filed (Month, Day, Year) State NOV 1 2 2004 Registrar

			For State Registrar	State of Ma		partment of Fertificate of			iene 201	04	35785
	Physici /Medio		Decedent's Name (First, Middle, Last) JOSEPH THOMAS					2. Date of Deat Month NOVEMbe			3. Time of Death 2:05A M
	Examir	_	4a. Facility Name (If not institution, give s Gilchrist Cent	er		Towsor	r Location of Death		4c. County of Bal	f Death timore	9
	Funeral Director		5. Social Security Number 6. Security Number 219-01-9645	7. Age	(In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day December	1, 1921	9. Birthplac Country Mary	e (State or Foreign and
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	rith the or 28a	Funeral Director	10e. Street and Number	<u>e</u>	TOWSOIT	10f. Zip Code		10	0g. Citizen of Wi		
	Jeath wins 23e	eral	6621 Charlesway	12. Was Decedent Ev	ver in U.S. 13		204 lispanic Origin? (Spe	ecify Yes or No-	US/	- American	Indian.
900	9 3 5	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XIX es 2 □ No If Yes, Give Year or Dates:	WWII	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXVo	an, Mexican, Puerto Specify:	Rican, etc.)		, White, etc. Whit	
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Č	and ZIZ be filed within tal Hygiene. ed other than evant, the M	Con	12 17. Father's Name (First, Middle, Last)		, <u> </u>	Executive	18. Mother's Name	(First Middle A	Meat		ng
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AM	, Mar and 2 sh salth and n 27 la m		19a. Informant's Name/Relationship (Ty, Louise Molesworth	oe, <i>Print)</i> Howard V	Wife 6621	Charleswa Charleswa	and Number or Aura By Towson	, Maryla	nd 21204	tate, Zip Co	ode)
:05	Nore,		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ R 4.□ Donation 5 □ Other (Specify)	emoval from State		position (Name of ematory or other place et Cemete)	(8)		20c. Location - C	-	
S S.	Dalfilmore, Marylat permit. Pages 1 and 2 should be Department of Health and Menta Importent: If them 27 Is marked any injury or other treumetic.		21 Ignature of Funeral Service License	Pen Ken	The second second second	22. Name and Addres	•	tchell-Wie	defeld Fu	neral H	lome Inc.
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NON	S, T	by	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contrib		ause of death?
WARD - N	The law reate has bee	Completed						24a. Was an autopsy perform	/ pri-	ere autopsy or to comple ath? Yes 2	findings available etion of cause of
HOWARD	OI VICAL F Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death			3103 2	, ,
2 5	Phys	on: To	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a. Date of Injury (Month, Day)	28b. Time	of 28c. Injury Work	4 □ Nursing Hor	me 5 Resider 28d. Describe hor			rospice
OSSEPH Pinio	UNISION I or Attending after death. Diractor: After	Certification:	Accident investigation Accident investigation	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)		Yes 2 □No	28f. Location (Str. City or Town,	eet and Number , State)	or Aural Ac	oute Number,
200	spita ours ours illed	cal Ce	29a. Certifier 1 Certifying Phys	sician: To the best of	my knowledge, dea	th occurred at the time	ne, date and place, a	and due to the ca	use(s) and mann	ner as stated	1.
~	To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	er: On the basis of e	od.						
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	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 2 2004	32 Registrar	s Signature	Print hacke					

Exprises 11-7-64 & 2:45PM Baltimore Maryland 21215-0136

Mary Virginia Jewkins

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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Marylar	Cei	rtificate of	Death	vieritai i sy	Reg. No.	004	3578	37
	Physici	an	Decedent's Name (First, Middle, La Jimmy	J.		Jenkins	Jr.	2. Date of De Month	Day	Year	3. Time of	M
}	/Medic Examin		4a. Facility Name (If not institution, given 50.7 WILSON BRI	e street and number) DGE ROAD		4b. City, Town, o OXON H	r Location of Death	NOV.	4c. C	2004 County of Death RINCE GE		_A [™] _
	Funeral Director		443-11-1729	Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di 10-7	rth ay, Year) '-61	9. Birth	place (State or intry) La.	Foreign
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or Lo	ocation					10d. Inside Cit	y Limits
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9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or Itams 23a or 28a-f show mith injury or other treumatic event, I'm Medical Evaluiter must be rediffed at once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Ameri Black, White, Specify: B		
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Maryland 21215-0036	d be filed a notal Hygie ed other is event, II	Be	17. Father's Name (First, Middle, Last) Jim		Jenkins	3	18. Mother's Nam Bessie		, Maiden S	Gumame) Wells		
aryl	should be and Mental s marked c	T _O	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street					o Code)	
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Baltimore,	permit. Pages 1 Department of + Importent: If ite eny injury or ot once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)	Luke Ce	osition (Name of matory or other place emetery	11-13	3-04	Ring	gold, La	a.	
Bal	permit Depar Impor eny in		21. Signature of Funeral Service Lice	nsee		Name and Addre March F.H				ce, Md. cth Ave.		
68760,	physician and burst-transit the burst-transit	cal Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	22/11/12/12	quence of):	ustet		0.00	illest,		Approximate Interval Betw Onset and C	veen
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٥.	quires that the de in signed by the a uld be detached t	by	Part II. Other significant conditions of	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		obacco use	e contribute to the	he cause of de bably 4 □U	
al Records,	The ate h page	Completed						24a. Was auto perfo		death?	opsy findings a impletion of ca 2 \(\text{No} \)	
Vital	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3□ DOA Oth	26. Place of Dea	th (Check only of ome 5 - Resi		V Other (Specif	AT SO	CENE
on of	ding h. Afte fune	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (onth, Day Year)	28b. Time or Injury	28c. Injur Wor		28d. Describe	- 4		97)	
Division	or life	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, str			28f. Location (City or Ton FYINCE	wn, State) s	Number or Rura	al Route Numb	er Ra.
	Hospitel 24 hours a Funerel I etely filled	dical (29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	пе, date and place pinion, death occu	and due to the	cause(s) ar	nd manner as s	tated. o the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	. 10.		29c. Licens			29d. Date :	signed (Month,		
	\bigcirc		> Zakirill				C.M.E		NC	OV. 4,	2004	
)		30. Name and address of person who ZABIUU AH	completed cause of death (Ite	m 23a) (Type, 11 Pen r	Print) n Street,	Baltimo	re, Mary	land	21201		
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 2 : 2004	32. Registrar's Sign		books						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Year **Physician** Greeny 06 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner FRANCE GEORGE'S HOSPITIAL CENTER CHEVERLY trince 5 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pey, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days 1 1 M 2□ F Mari Director none Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. mportant: if item 27 is marked other then "natural", or itame 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits item 27 is marked other then "natural", or itame 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Prince George's Riverdale Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 20737 6025 67th Avenue #5 TISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: black Š 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kontina Ziegler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Prince George's Hospital Center 3001 Hospital Drive Cheverly, MD 20785 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition etery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State iny injury or 4□Donation 5 MOther (Specify) in state 21. Signatur Funeral Service Roman S. Wade 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Miscel Baltimore, MD 21201 nt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner signed by the attending physician end d be detached for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed theiria Invembocytopenia 2 1 No 1 🗆 Yes 1 ☐ Yes 2 ☐ NO Attending Physician: 25. Was case referred to medical the funeral director, Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident s efter death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ò To the Hospital of within 24 hours of To the Funeral D 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dev. Yeer) 29c. License number 29b. Signature and title of certifier Lamax 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, HOSPITAL PRIVE 3001 - JENNINGS 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 2 2004

DHMH 16 Rev 6/95

Registrar

			e of Maryland / De		lealth and M		esooi	35789
Physicia /Medica Examine	al	Decedent's Name (First, Middle, Last) Baby Girl Johnson Aa. Facility Name (If not institution, give street and an analysis)	od number)	4b. City, Town, or	Location of Death	11 3	ay Year 2004	3. Time of Death
Funeral Director		5. Social Security Number of Sex 1 M 2 M Usual Residence of Decedent		Months Days	If Under 24 Hrs. Hours Min. 37	8. Date of Birth (Month, Day, Year Nov 3, 200	Q Diethole	IORE lice (State or Foreign y) and
he Maryland 28a-f show	ector	10a. State 10b. County MD Baltimore	10c. City, Town or	sex				d. Inside City Limits 1 □ Yes 2√ No
ould be ified within 72 hours after death with the Maryland Menial Hygiene. arked other than "natural", or Itama 23a or 28a-f show afte svent, the Medical Examinar must be rediffied at	y Funeral Director	1 Never Married 2 Married 1 If Ye	Yes 2. No s. Give	10f. Zip Code 212. 3. Was Decedent of Hi II Yes, specify Cubai 1 ☐ Yes 2 ☑ No			USA 14. Race - Americal Black, White, et	n Indian, c.
within 72 hours iene. rthan "natural", the Medical Exi	Completed by	15. Decedent's Education (Specify only highest grade complete	or Dates: 16a. De (G (G (ife)) (G (ife)) (ife) (G (ife)) (ife) (G (ife))	ocedent's Usual Occupa ive kind of work done of a. DO NOT use retired,	ation during most of work	ng	Specify: blac Kind of Business/Indu	
2 should be filed withir and Mental Hygiene. Is marked other than aumatic avent, the Ma	To Be C	17. Father's Name (First, Middle, Last) John Lee 19a. Informant's Name/Relationship (Type, Print	100 14	alling Address (Ctools	Mardeli	(First, Middle, Maider ne Johnson	n Sumame)	
permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marks any injury or other traumatic ance.		Franklin Square Hospit 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) in	a1 900 from State 20b. Place of Discemetery, of	ailing Address (Street a 10 Franklin sposition (Name of crematory or other place	Square I	rive Balti		21237
permit. Departm Importa any inju		21. Signatura of Funeral Service Licensee Romald S. Wards	Director	22. Name and Addres State Anato Baltimore,	omy Board MD 2120	655 W. Ba	ltimore St	reet
ysicie	dical Examiner	Immediate Sause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of): TERM PERMAT e to (or as a consequence of): FETTION Sa e to (or as a consequence of): PETTION Sa e to (or as a consequence of):	Y URE Rupte Spected			lr C	oproximate nterval Between Onset and Death
tt the death certificate bby the attending physic lached for use as the b	Physician/Med	in the past 12 months?		3 Ectopic pregnancy 5 Other (specify)			23d. Date of delivery Month Da	ay Year
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To the Hoapital or Attendi	al Certification;	4 Homicide	Place of Injury - At home, larm, building, etc. (Specify)			28f. Location (Street ar City or Town, State	9)	
To the Hos within 24 hr To the Fun completely	Medical	(Check only 2 Medical Examiner: On t	o the best of my knowledge, de he basis of examination and/or manner stated.	29c. License	inion, death occurre	ed at the time, date and	and manner as stated place, and due to the tesigned (Month, Da	e cause(s)
State Registra	e	DR. Alic Tabin- Will	eause or death (Item 23a) (Typ		y AKE DK	BAITIMO	THE MA	2/237

Jehnson

BABY GIRI

			State of Maryland / Department of Health and M		ene 004	35790
	Physici		1. Decedent's Name (First, Middle, Last)	Oct 31,	Day Year	3. Time of Death 23:11P M
	/Medio		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Clinton		4c. County of Dea	th eorge's
	Funeral Director		5. Social Security Number 145 16 4112 G. Sex This M 2 F X This M 2 F X This M 2 F X This M 2 F X This M 2 F X This M 2 F X This Months This M	8. Date of Birth (Month, Day, June 20	Year) Co	thplace (State or Foreign ountry) irginia
	perril. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Impertant: if itam 27 is marked other than "natural", or itams 23a or 28a-f show my injury or other traumatic event, the Medical Evanties must be routlied at once.	rector	10a. State 10b. County 10c. City, Town or Location Maryland Prince George's Upper Marlboro 106. Street and Number 107. Zip Code	10	og. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX ountry?
	death with ims 23a or r must be	Funeral Director	8414 Grandhaven Ave 20772 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto		Inited Sta	erican Indian,
9036	ours after iral', or ita	þ	1 □ Never Married 1 □ Yes 2 □ No lt Yes, Give A \ 3 □ Widowed 4 □ Divorced Year or Dates:		Black, Whi	Black
21215-0036	l within 72 h iene. r than "natu the Medice	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12t 16a. Decedent's Usual Occupation (Give kind of work done during most of work) (Give kind of work done during most of work) (ife. DO NOT use retired) National Security Agenc		Analysis	/Industry
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Mary	and 2 sho ealth and P n 27 is me		Janet S. JOnes (Wife) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 8414 Grandhaven Ave,			
Baltimore,	Pages 1 annent of He ant: If itam ury or other			Date 2	Clinton. N	Town, State
Balt	perrit. Pages Depirtment of Important: It i any injury or once		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Alexandria FerryRd,	Funeral Clinton	Home,Inc , Maryland	663301d 1 20735
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8760, <	Examiner	cai Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			24113
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Vital Records,	The lasate has	Completed	PANKIN SVAS SYNDRIME	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of 2 No
f Vita	Physician: Th rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	233	nce 6 Other (Spe	cify)
Division of	ding After fune		Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	28d. Describe ho	w injury occurred	
Divis		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Re State)	ural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Dirac completely filled in by	Medical	29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	te and place, and due	o to the cause(s)
•	with To 1	2	29b. Signature and title of certifier D-00 (4013 (MO))		d. Date signed (Mont 1/3/04	h, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Caruso, M.D. 770001d Branch Ave Suite #D203, C1			0735
E	Sta Registi		31. Date filed (Month Day Year) 2004 32. Registrar's Signature & Sparks			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Day Month **Physician** Helen Ada Johnson 55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 28, 1 59 SPITON Male OnKlin 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 1 F Yrs. 212-20-0694 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore Direct 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10516 Byrd River Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Grayson Townsley Sara Anna Combs ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philis P. Carbonell / Daughter 4026 Sharilyon Drive, Abingdon, MD 21009 of Disposition (Name of Date 20c. Location City or Tov 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 11-10-04 Towson, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 0/00 2 No 1 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diab 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide

Box 68760 Division of Vital Records, The law requires that the death certificate be executed

Funeral

Director

ral', or Items 23a or 28a-f show Examiner must be notified at

"natural"

la marked other than "natur raumatic event, the Medical

Important: If item 27 is any injury or other trac once.

Physician

/Medical

Examiner

iding physician and ise as the burial-transit

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certificate

this After this funeral c

the Director:

filled in by within 24 hours after To the Funeral Direc

Medical

Hospital or Attending Physician:

the e

Mental

filed within 72 hours after

21215-0036

Maryland

Baltimore,

3

Registrar

Ur. Gienn Meininger 31. Date filed (Month, Day, Year) NOV 1 2 2004

4 | Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifie

30. Name and address of person who completed cause of death (Item 23a) Type, Print) 9000Frankl 32. Pegistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ive Baltimor

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State of M	aryland / Department of Health and Menta Certificate of Death	Hygiene 2004 35792
	Physici		Decedent's Name (First, Middle, Last) Richard Byron Kalter	2. Date	e of Death 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) MOSUJONA GENERAL A	lospital Baltimore City	4c. County of Death N/A
	uneral irector		5. Social Seturity Number 6. Sex 7. Ag 284-20-4115 1	Months Days Hours Min. (Mor	of Birth, Day, Year) St 4,1925 9. Birthplace (State or Foreign Country) Ohio
odeath with the Maryland	show	or	10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits 1▼ Yes 2 □ No
ith the N	or 28a-f show to natified at	Jirect	Maryland N/A 10e. Street and Number	Baltimore 10f. Zip Code	10g. Citizen of What Country?
36 s after death w	"netural", or Items 23e or 28a-1 shov policial Exerciper must be notified at	by Funeral Director	1504 West Mt. Royal Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1504 West Mt. Royal Avenue 12. Was Decedent Armed Forces? 1 Yes 2 Never Married 2 Married State Sta	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	s or No- tc.) 14. Race - American Indian, Black, White, etc. Specify: White
5-00 72 hour	netural dical E		3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
2121 21211 d within	C 42	Completed	Elementary/Secondary (0-12) College (1-4or: 5+	Philosopher / Theologist	Teacher / Clergyman
land 2	nd mental ryglene. marked other than matic event, Ite M	To Be (17. Father's Name (First, Middle, Last) Ozro E. Kalter	18. Mother's Name (First, Pauline B.	
(0 0 0	is mar raumat	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route	-
ore, M	Department of result and mental ryglene. Important: If Item 27 is marked other that any injury or other traumatic event, ILEM ODCS.		Mary Fredlund / Friend 20a. Method of Disposition	20b. Place of Disposition (Name of cometery, crematory or other place) 20b. Place of Disposition (Name of cometery, crematory or other place)	re Maryland 21217 20c. Location - City or Town, State
alltimo	rtant		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service (Consee	Metro Crematory Inc. 11/12/04	
D be mind	lmpo any ir		Thomas Gregor		timore, Maryland 21228
Phy	ysician		shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	the death. Do not enter the mode of dying, such as cardiac or respirane. SCONDARY TO PREMIONA	Interval Between
), executed	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Check of the Chec	a consequence of): Brain Damage a consequence of): C Encephal opathy a consequence of):	
Records, P.O. Box 68760 The law requires that the death certificate be e	y the allending phiched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
rds, P	been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death b	ut not resulting in the underlying cause given in Part I. 23e	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	2 38	Completed			. Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No
f Vita	this certifi al director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie	26. Place of Death (Check	only one) Residence 6 □Other (Specify)
Division of Vital	fter	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ry y Year) 28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No 28d. Des	cribe how injury occurred
DIVIS	s arrel dead	Sertifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et	ury - At home, farm, street, factory, office c. (Specify) 28f. Loca City	ition (Street and Number or Rural Route Number, or Town, State)
e Hospii	within 24 rous after death. To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner street.	of my knowledge, death occurred at the time, date and place, and due examination and/or investigation, in my opinion, death occurred at the sted.	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)
	To th comp	Me	29b. Signature and the of confifer WAIR	29c. License number 89532	29d. Date signed (Month, Qay, Year)
V			30. Name and address of person who completed cause of d	eath (Item 23a) (Type, Print) Maryland Grenkfal He	spital
0	Sta Registr		31. Date filed (Month, Day Year) 32. Registr	ar's Signature & Asparl	

State of Maryland / Department of Health and Mental Hygiene 0 0 4 35793 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 31, James G. Keeney 2004 12:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3207 Jeffrey Lori East Finksburg Carrol1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Dec 27, 1922 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1X M 2□ F 220-18-7705 81 Dec Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√ No Carroll Finksburg Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3207 Jeffrey Lori East 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 143-45 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) chemist permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If Item 27 is marked other th
eny injury or other traumatic event, Illie
once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gordon Arthur Keeney Ida Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edith Keeney/spouse 3207 Jeffrey Lori East Finksburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 □ Other (Specify) 21. Signatur of Pr., ral Se. Licensee Nade 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mos Physician alu CONG /Medical Due to (or as a consequence of): Examiner 15CL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an page 2 1 ☐ Yes 2 1 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: Af
d in by the fur 2 Accident JOW-E 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a
To the Funeral C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 90 PAINTERS MILL RD SUITE 135 MD 21117 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State 2 2004 Registrar

DHMH 17 Rev 1/2001

				State of Maryland / Department of Certificate o			2004	35794
				Registrar Certificate 0 1. Decedent's Name (First, Middle, Last)		Reg.	NO.	3. Time of Death
		Physici /Medic		JOHN CLARK KECKLEY	N	JOVEMB	PT 19.20	4 3:00PM
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town	n, or Location of Death		4c. County of Death	
				Good Gamaritan Hospital Bal-	timore		NA	
		Funeral		5. Social Security Number 6. Sex 7. Age (fh yrs. last birthday) If Under 1 Yes 12 M 2□F 7. Age (fh yrs. last birthday) Months Day	ys Hours Min.	Date of Birth (Month, Day, Ye	gar) Cou	place (State or Foreign ntry)
		Director		223-14-7811 86 Yrs. Usual Residence of Decedent	9/	/12/1918	WES'	VIRGINIA
		show		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
(B)		the Ma 28a-f s	cto	MD BALTIMORE GLENMONT				1 ☐ Yes 2 X No
V		with the	Funeral Director	10e. Street and Number 10f. Zip Code			. Citizen of What Cou	ntry?
Ū		eath w	eral		1239 of Hispanic Origin? (Speci		USA 14. Race - Amer	can Indian.
Keckley	(0	urs after death with the Maryla al', or Items 23a or 28a-f shov Extaniher mast be maiffed at	표	1 Never Married 2 Married 1 XYes 2 No	of Hispanic Origin? (Speci Suban, Mexican, Puerto Ri	can, etc.)	Black, White	, etc.
X	5-0036		d by	3 DWidowed 4 Divorced If Yes, Give Year or Dates: WWII	No Specify:		Specify: WHI	TE
1/	5	"netur	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done) (if the DO NOT use ret	ne during most of working	161	b. Kind of Business/li	ndustry
7	12	withir ene. then	dmo	Elementary/Secondary (0-12) College (1-4or 5+) Z YEARS SELF EMPLOYE	,	I	HOSPITAL S	UPPLIES
2	<u>d</u>	be filed with tal Hygiene. d other ther event, It e N	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (i	First, Middle, Mai	iden Sumame)	
V	<u>la</u> n		To B	JOHN F. KECKLEY	HARRIETI	GLEN		
John	Maryland	and and sum	0 8	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Stre</i>	et and Number or Rural F	Route Number, C	ity or Town, State, Zi	p Code)
2		s 1 and 3 f Health itam 27 othar tra		CLAIRE SIMMS FRIEND 51 DUNGARRIE 20a. Method of Disposition 20b. Place of Disposition (Name of		NSVILLE,	MI) 2122 c. Location - City or T	
17	altimore,	of of or		1 → Burial 2 □ Cremation 3 □ Removal from State	place)		•	
	Ħ			'4 Donat/on 5 Dother (Specify) OAK LAWN CEMETER 21. Signature of Funeral Service Licensee 22. Name and Add	RY 11/13 dress of Facility THE		EASTPOINT,	
	Ba	permit. Departr Imports eny inju		Heather V. Hull 8521 LOCK	H RAVEN BLVD			286
				23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of defended, or heart failure. List only one cause on each line.				Approximate Interval Between
		Pnysician			le Garain	oma		Onset and Death
		/Medical Examiner		resulting in death) Due to (or as a consequence of):				1000
			-	Sequentially list conditions, if any, leading to immediate b.			_	
		uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
M	ó	exectan and rial-tra		resulting in death) Last Due to (or as a consequence of):				
4	976	ate be nysicie he bu	dical	d			-	
	9	ertific ling p	Мес	IF FEMALE: 23c. If yes, outcome of pregnancy				
	Вох	attend for us	Physician/Me	in the past 12 months?			23d. Date of delive Month	ery Day Year
	P.O.	the de y the	ysle	1 Yes 2 No 9 Unknown				
		s that ned b e deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobac	co use contribute to	he cause of death?
	rds	en sig	ed t			1 🗆 Yes	2DNo 3□Pro	bably 4 □Unknown
	ecc	law re as be	ompleted			24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
	H H	The cate h	Соп			performed 1 ☐ Yes 2 ☐		2 No
	Vita	iclan: sertific	Be	25. Was case referred to medical examiner?	26. Place of Death (
	of	Phys r this ral dir	. To	To Tes 2 Envolupation 3 Box	4 Not sing Home	d. Describe how	e 6 □Other (Speci injury occurred	fy)
	lon	th. : Afte	atlon		Mork? □Yes 2□No			
	Division of Vital Records,	I or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)	ce 28	f. Location (Stree City or Town, S	t and Number or Rur State)	al Route Number,
	Ö	ital or irs afte ral Dir led in		/				
		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in m and manner stated.				
_		Vithin To the comple	Me		ense number	29d.	Date signed (Month,	Day, Year)
		X		Charles Xad x to DI	55410	Nr	Vember	11,2004
		10		30. Name and address of person who complete cause of a th (Item 25.) (Type, Print)	101			71000
				31. Date filed (Month, Day, Year) 32 Prodistrar's Signature	ven Blud,	Baltin	nore IVID	4139
		Sta Regist		31. Date filed Worth, Day, Year 32 Registrar's Signature Space	2			

			For State Registrar	State of	Marylan	d / Depa		of Heal	th and M	lental Hy		2001.	35795
			Decedent's Name (First, Middle, La	ist)						2. Date of De	ath		3. Time of Death
	Physici /Medio		ROBERT MICHAEL KOZLO	DWSKI						NOV.	5 5	y Year 2004	9:05A [™]
	Examin		4a. Facility Name (If not institution, gir	e street and num	ber)		4b. City, Tov	wn, or Loca	ation of Death		4c.	. County of Death	
			Upper Chesapeak	e Hospita	1			lair				Harfor	db
	Funeral			Sex 7	'. Age (In yrs. I	last birthday) Yrs.	If Under 1 Y Months D		Inder 24 Hrs. ours Min.	8. Date of Bir (Month, Da	rth a <i>y, Year)</i>	Cot	place (State or Foreign intry)
	Director		218~40~4435	(X	_63	115.				Oct. 2	28,19	141 Mary	yland
	aryland ahow		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Man B-f ah	ţċ	Maryland Harfor	d		Stre	eet						1 ☐ Yes 2☐No
	th the	ire	10e. Street and Number				10f. Zip Co	ode			10g. Cit	izen of What Cou	intry?
	eath with the Marylan s 23a or 28a-f ahow ust be redilled at	Funeral Director	4323 Madonna Rd.					211				USA	
	tems	nue	11. Marital Status	12. Was Deced	ces?	S. 13. \	Was Decedent f Yes, specify	t of Hispani Cuban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No Rican, etc.)	D-	 Race - Amer Black, White 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Da	XX les:		1□Yes 2□	No Spe	ecify:			Specify: Wh	ite
600	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow re M. Alcal Ext. airer i ust be ricillised at	ted	15. Decedent's E	ducation		16a. Deced	dent's Usual O	Occupation			16b. K	ind of Business/li	ndustry
215	hin 7.	pie	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-	4or 5+)				most of work	ing			
21	ygien /gien er th	Completed	8th grade	N/A		T ₁	ruck Dr				d	liams Sc	ottsman
pu	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, Las	t)						e (First, Middle	, Maiden	Sumame)	
<u>Ş</u>	should nd Mer nmarke nmartic	P.	Joseph Kozlowski	(Time Drint)		105 14-10-	- Add (C		Agnes B		0"	. T O T	
Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma M	d 2 st th and th and traur		19a. Informant's Name/Relationship			0.275	No. out					or Town, State, Zi	
11/5/05 timore, Ma	Heal Heal tem 2		Lisa M. Demond (D 20a. Method of Disposition	augnter)	20b. P	lace of Dispo	sition (Name of	of		rretts. Date		e, Md. 2 ocation - City or T	
/ em	ages ent of nt: if i		XX Burial 2 ☐ Cremation 3 (`4 ☐ Donation 5 ☐ Other (Special				Cemete		10-11	.~04	Fal	lston, M	d.
0965 Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic avant, IT & ODE.		21. Paure of Funeral Service Lice		-)		. Name and A			7/	NI R	Belair Ro	4
m	9 9 11 6 8		Methor 108	aho (A	SOOR	Ci	Lassahi	n Fun	eral Ho			ore, Md	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that ca one cause on ea	used the death ch line.					or respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_ a <	Long	1 00	ncar	- (nete	state)		Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (c	r as a cons	ence of):		-					
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م م	res that the de signed by the a l be detached f	by Pł	Part II. Other significant conditions	contributing to dea	ath but not resu	ulting in the u	nderlying caus	se given in f	Part I.	23e. Did t	tobacco u	use contribute to	the cause of death?
+ rds	w require: been sig should b									11	Yes 21	□No 3□Pro	bably 4 □Unknown
Records,	e taw re has bee	Completed								24a. Was		24b. Were aut	opsy findings available ompletion of cause of
S, R	The late has page	mo.								perfo	rmed?	death?	2□ No
/ital	aician: Th certificate irector, pag	Be (25. Was case referred to medical examiner?						Place of Death	(Check only	one)		
of of	Phyai this o	2	1 Yes 2 No	1		ER/Outpatien 28b. Time of				me 5 Resi		6 □Other (Speci	fy)
lowsk	ding F h. After funera	tion	1 Natural 5 ☐ Pending	28a. Date of (Month	, Day Year)	Injury	M 200.	Injury at Work? 1 Yes		280. Describe	now injur	y occurred	
2 lowsk	*Attanding Phyaic sor death. Fector: After this ceby the funeral directors.	fica	3 Suicide 6 Could not I	28e. Place o	of Injury - At ho	ome, farm, str	eet, factory, of		-	28f. Location (Street an	d Number or Run	al Route Number,
o2 Div	ours after ours after neral Dire	Certification;	4 Homicide	buildin	g, etc. (<i>Specif</i> y	/)			4	City or To	wn, State)	
X	• Hospital or Attan 24 hours after deatl • Funeral Director: etely filled in by the	edicai (29a. Certifier Certifying P	hysician: To the I	pest of my knows	wledge, death	occurred at the	he time, da	te and place,	and due to the	cause(s)	and manner as	stated.
	를 들 를 들	Medi	one)	and mann	er stated.								
	To To	~	29b. Signature and title of certifier	1111	i in -	1.0	_	icense num			∠90. Dat	te signed (Month,	Day, reaf)
			20 Name and address of passes with	Completed saus	of death (lis-	23a) /Time		1279			1/1	13/04	
	6		30. Name and address of person who	Me m	1 6/	I An	aelh	us D.	nd.	200 x	fer.	Mn 6	2014
	Sta	ite	31. Date filed (Month, Day, Year) NOV 1 2 2004	62. Re	gistrar's Signa	turd	lon 1			14	1 /		No. 1
	Registr	rar	MAATE COOL		/	, - /	7						

				For State Registrar	State of	Maryland		irtment of H	lealth and N Death		giene Reg. No. 0 ()4	35796
				Decedent's Name (First, Middle,	Last)					2. Date of De	ath	Voor	3. Time of Death
		Physici /Medio		Frank	k Eugene	Lanham,	Sr.			NOV.	10, 2004	Year 	11:13p M
		Examin		4a. Facility Name (If not institution,		nber)			Location of Death		4c. County		
				Joseph Richey		7 A (la la	and the State of the cold	Balti If Under 1 Year	IMOre If Under 24 Hrs.	O Data of Dia		N/J	
		Funeral Director		5. Social Security Number 216–16–2993	6. Sex 1 M 2 □ F	7. Age (<i>In yrs. I</i> a 81		Months Days	Hours Min.	8. Date of Birt (Month, Da SEP 24	, Year) 1923	New	place (State or Foreign Intry) York
				Usual Residence of Decedent						DEI 27	, 1)20	IVCW	TOLK
		rylan show		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 XNo
		8a-f s	Director	Maryland Howa	ard				ott City		40. 000	#	
		death with the Maryland ms 23a or 28a-f show r nust be notified at		10e. Street and Number 4938 Eastwood	Court			10f. Zip Code	043		10g. Citizen of V USA	mat Cou	intry?
		leath	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S	S. 13. V		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No			ican Indian,
	9	after or Iten	Fun	1 Never Married 2 Marrie	Amed For	ces? 2 No WWII	1	fYes, specify Cuba I□Yes 2፟XINo		Rican, etc.)	1	k, White	, etc. White
	<u>8</u>	ours a	dby	3 Widowed 4 Divorced	Year or Da	tes: WWII		Tes ZAINO	Specify:		Specify	:	WIII CE
	5-	"natu	lete	15. Decedent's (Specify only highest			(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most of work	ing	16b. Kind of Bu	sin e ss/Ir	ndustry
	12	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		nter	,		Printi	ng	
	9	filed Hygi other	Be C	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam	e (First, Middle,			
	ılan	uld be Aenta rrked tic ev	To B	Howard Car	l Lanham				Eva M	lae Ritt	er		
	lar)	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, It is Modical Examiner must be multified at		19a. Informant's Name/Relationsh	p (Type, Print)				and Number or Rur				
	o, ≥	l and lealth om 27 her tr		Eileen M. Lanhar	n/wife	20h Pla		Eastwood sition (Name of		llicott	City, N		
	وت	ages of the of the or of the or or or or or or or or or or or or or		1 ☐ Burial 2 🕅 Cremation		CA	metery cren	natory or other plac			Baltin	•	
10	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra ances.		' 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of unitral Service I		11							, 1112
2/2	Ba	permil Depar Impor any ir	3	Mayn F	McDonald	alo			°Society rick Road				28
1				23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that controls one cause one	aused the death.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rest,	2	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	C	MONI	1 AK	STVIM	1110 90	U/MO)	12111	/,	Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	2111101	100/0	1111.071	914		1/1
	н	LAdminer	<u></u>	Sequentially list conditions,	b. Due to (or as a conseque	ence of):				-	_	£
74		ited	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	23010 (or as a somoods.	51100 017.						
1	Ć,	execunand and ial-tra	Exal	resulting in death) Last	c	or as a conseque	ence of):	***					
1	8760	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d								
-	9	artifica ing ph e as th	Med	IF FEMALE:								1	
	Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	come of pregnan irth 2 □ Fetal ant at time of de	death 3□	Ectopic pregnancy Other (specify)			23d. Dat Mor		ery Day Year
2	P.O.	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkno		am ⊃∟	Other (<i>specify</i>)					/
ham	۵.	wrequires that the debeen signed by the should be detached		Part II. Other significant condition	ns contributing to de	eath but not resul	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contr	ibute to	the cause of deal
7	rds	quires an sign	q pa	THIMON	JAN	YIDY	25/3	5		10	res 2□No	31 Pro	bably 4 Inknown
anl	Records,	aw re	plet							24a. Was		Vere auto	opsy findings available
7		The ete ha	Completed by	//						perfo	rmed?	eath?	2□ No
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H	of Vital	Physician: r this certifice ral director, I	To	1 Yes 2 No		npatient 2 E	R/Outpatien 28b. Time of		4 Nursing no	ome 5 Resident	dence 6 (2) the		MOSTICE
		ding Afte fune	tlon	1 L atural 5 ☐ Pending 2 ☐ Accident investig		of Injury th, Day Year)	Injury	Wor	k? Yes 2 □No		,,		
X	Division	I or Attendi after death. Director: A	ifica	3 Suicide 6 Could n	nod 206. Flace	of Injury - At hor	me, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number	er or Rur	al Route Number,
ran	Ö	safte al Dir	Certification:	4 Horricide	buildi	ng, etc. (Specify)	/			City of You	vn, State)		
12		To the Hospital or Attu within 24 hours after de To the Funeral Direct completely filled in by th	edical	(Check only 2 Medical E	Physician: To the examiner: On the ba	asis of examinati							
7		thin 2 the I	Med	one) 29b. Signature and title of certifies	and mani	ner stated.		29c. Licens	e number		29d. Date signed	(Month,	Day, Year)
		F 3 F 8		Valua A	PHINE	MO		10/2	3017		11/11	10	1
		h		30. Name and address of person y	who completed cays	e of death (Item	23a) (Tyge,	Printy	10	10.1	11/1/	1-	10
51				JOHN KIT	TIME	431	IMM	Neruno	DA MA	Dah	0. MA	2	211
da		Sta Regist	ate	31. Date filed (Month, Day, Year)	2 2004 32. R	egistrar's Signati	ure	9 Som	Kal		/		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Denastment of Health and Mental Hydienes of the state of Manyland / Denastment of Health and Mental Hydienes of the state of Manyland / Denastment of Health and Mental Hydienes of the state of Manyland / Denastment of Health and Mental Hydienes of the state of Manyland / Denastment of Health and Mental Hydienes of the state of Manyland / Denastment of Health and Mental Hydienes of the state of the s

M 			1 - For Unpend Item Registrar	23a, pt.11,	27 per me Ce	tificate of	Death	ntal Hygle Reg.	2004	35797
	Physicia	an	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Kimberl 4a. Facility Name (If not institution, giv			4h City Town o	r Location of Death	OVEMBER	7, 2004 4c. County of Deat	2:35 P M
_	Examin	er_	13 CROMWELL AVE	0 00,000 and 11200,		GLEN BU			ANNE ARU	
1387	Funeral Director		217-72-6099	Sex 7. Age 1 □ M 2 X F	9 (In yrs. last birthday 45 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yeal)		nplace (State or Foreign untry) yland
7	land		Usuaf Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary -f sh	tor	Maryland N/	Α	Ŧ	Baltimore				1 XYes 2 ☐ No
	or 28e	irec	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What Co	untry?
	ath wi	rai	2649 Dulany				21223	:	USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel" or iteme 23s or 28e-f show any injury or other treumstic event, If a Modical Examination to other treumstic event, If a Modical Examination to other treumstic event, If a Modical Examination to other treumstic event, If a Modical Examination to other treumstic event, If a Modical Examination to other treumstic event, If a Modical Examination to other treumstic event, If a Modical Eventual Examination to other treumstic event, If a Modical Eventual Eve	d by Funeral Director	11. Marital Status 12 Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036	within 72 h ine. i.hen "netu i. M. alica	Completed	15. Decedent's E (Specify only highest grant of the secondary (0-12) 1.2	ducation ade completed) Coflege (1-4or 5	(Give	DO NOT use retired	during most of working	161	b. Kind of Business/	
2	filed v Hygie ther t		17. Father's Name (First, Middle, Last		IN/ F		18. Mother's Name (First, Middle, Mai	Never Wo	orkea
an	ld be ental ked o ic eve	To Be	Thomas Lewis	•				Babette	•	
	nd 2 shou aith and M 27 is mar r treumati	-	19a. Informant's Name/Relationship (Joan Babette Coc				and Number or Rural P Street Bal			ip Code)
Baltimore,	Pages 1 a nent of Hec ant: If item ary or othe		20a. Method of Disposition 1 Burial 2 Acremation 3 C 4 Donation 5 Other (Speci			osition (Name of ematory or other place ematory,	Inc. 11/9/		Baltimore	
Balt	permit. Departr Importe any inji		21. Signature of Funer I Service Line Dawn F McDo	nald	12	99 Freder	Society of	Baltimor	ce. MD 212	228
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	PULMONARY	ABSCESSES	TTIS ASSO	ng, such as cardiac or i	respiratory arrest. I MYOCAR	DIAL AND	Approximate Interval Between Onset and Death
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	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	a consequence on.					
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P.O. Box	death cer e attendin d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ★ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	4		23d. Date of deli Month	very Day Year
	quires that n signed b uld be deta	by	Part II. Other significant conditions SEPSIS	contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.			the cause of death?
Division of Vital Records,	6	Completed						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2 No
/ita	cien: artific actor,	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of Death (Check only one)		
on of \	ng Phy fter this	tion: To	XX/es 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatie 28a. Date of fnju (Month, Day		of 28c. Injur	4 Nursing Home	e 5 ☐ Residenc d. Describe how	e 6 X Other (Specinifury occurred	city) SCENE
Divisi	al or Attending s after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	De Place of Init	ury - At home, farm, s c. (Specify)	treet, factory, office	28	f. Location (Stree City or Town, S	st and Number or Ru State)	ral Route Number,
	To the Hospitel or Attendii within 24 hours after death. To tha Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of miner: On the basis of and manner sta	f examination and/or i	th occurred at the time	me, date and place, an opinion, death occurred	d due to the caus I at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To t To t com	Σ	29b. Signature and title of certifier	mid		29c. Licens	OCME		Date signed (Month VEMBER 8,	
_			30. Name and address of person who	D.		, Print) 111 Po	enn Street,	, Baltim	ore, Mary	land 21201
	Sta Regist		31. Date fifed (Month, Day, Year) NOV 12		ar's Signature	Sperte				

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I rtificate of	lealth and		ene2004	35798
	Physici /Medic		1. Decedent's Name (First, Middle, Las Dorothy F. Lane	")				2. Date of Death Month November	Day Year	
	Examir		4a. Facility Name (If not institution, give Elder Care Garder	s		Linth			4c. County of Dea	rundel
	Funeral Director		5. Social Security Number 6. Security Number 215–01–7335	X 7. Ag	88 Yrs.	If Under 1 Year Months Days				rthplace (State or Foreign ountry) aryland
	Maryland a-f show	ctor	10a. State 10b. County Maryland n/a		10c. City, Town or Lo Baltimo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23e or 28	Funeral Director	10e. Street and Number 5011 Frederick Av	enue		10f. Zip Code 21 229			g. Citizen of What C United St	
9800	n 72 hours after death with the Maryland "netural", or Items 23e or 28a-f show dical Examinational be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☆Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 M If Yes, Give Year or Dates:	No	If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Pue Specify:		14. Race - Am Black, Wh Specify:	White
Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho to Health and Mental Hygiene. If Item 27 is marked other then "netun or other treumatic event, the Mudical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or	(Give	dent's Usual Occup kind of work done DO NOT use retire ales Pers	during most of w	rorking	6b. Kind of Business Retail	
land 2	12 should be filed within " h and Mental Hygiene. 7 is marked other then " reumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last) Noble Friskey			ares rer	18. Mother's N	ame (First, Middle, M. hine Casse	aiden Sumame)	24100
	and 2 shores alth and he 27 is ma		19a. Informant's Name/Relationship (7 John W. Lane, Jr.		237	Laverne A		Rural Route Number, Lansdowne,	-	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tre <u>900</u> 9.		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify)	Loudon P	matory or other pla ark Cemet	tery 11		oc. Location - City of Baltimore,	
Bali	permit Depart Import eny in		21. Signature of Funeral Service Licen	Lind	4		ens Aven	Hubbard Fu ue, Baltim	ore, Mary	land 21229
8760,	Physician / Medical physician and physician and physician and physician sit in principle of the physician and phys	dicai Examiner	23a. Parti. Enter the disease, or comp. shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease or hijury that initiated events resulting in death) Last	a	ne.	nelr	ig, such as calul	ac or respiratory arres		Approximate Interval Between Onset and Death The Manual Control of the Control o
P.O. Box 68	death certific e attending p od for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of de Month	livery Day Year
	as gn 90	ed by Ph	Part II. Other significant conditions or	ntributing to death b	out not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba 1 □ Yes		o the cause of death?
al Records,	The law ate has b page 2 sh	Completed						24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings available completion of cause of
ion of Vital	Attending Physicien: The death. ector: After this certificate by the funeral director, pagon	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		f 28c. Injui Wor	ner: 4 🗍 Nursing	eath (Check only one) Home 5 Residen 28d. Describe how	ce 6 Sother (Spe	assistery every
Division	tel or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical ((Check only 2 Medicel Examone)	sicien: To the best iner: On the basis o and manner st	of my knowledge, deat if examination and/or in ated.	vestigation, in my o	ppinion, death occ	curred at the time, date	e and place, and due	e to the cause(s)
	₩	2	29b. Signature and title of certifier	Biru	hesinus		22114	290	1. Date signed (Mont	rh, Day, Year)
			30. Name and address of person who o	RABRICO	K ROAD, S	Print) DAM		KLACHES YLMORE,	no di	219
	Sta Registi		31. Date 10 Month, 22/2 (04	32. Registr	rar's Signature	,				

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PHTIENT LENGONIN AS ALBERTAL. LOMAX Baltimore. Marvland 21215-0136

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State of Maryland / Department of He	ealth and Mental Hygiene

			1 - For State Registrar	State	of Maryland			t of Heal <i>e of Dea</i>			giene Reg. No.	004	35	799
	Physici /Medic		1. Decedent's Name (First, Middle Alberta L.							2. Date of Dea Month NOVEM	Day	2004	3. Time (of Death 20 AM
ı	Examin		4a. Facility Name (If not institution	OSPITI	AL OFBA	LT) Mozi	4b. City,	Town, or Local	MOPE Inder 24 Hrs.	CITY	4c. Co	unty of Death	1	
	Funeral Director		5. Social Security Number 212-78-3084 Usual Residence of Decedent	6. Sex 1	7. Age (In yrs. Ia		Months		ours Min.	8. Date of Birt (Month, Day Sept 30	у Year) 195	9. Birth Con	nplace (State untry)	or Foreign unk
	be filed within 72 hours after death with the Maryland the Hygieno. d other than "netural" or liems 23e or 28e-1 show event, the Maryland Examiner must be motified at	ector	10a. State Unk 10b. County		unk 10c. City,	Town or Lo		Code		unle	10g Citizon		10d. Inside 0	•
	ath with	Funeral Director		nk 12 Was Do							Ţ	JSA		
0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Important: If inm 27 is marked other than "netural", or liems 23e or 28e-1 show any injury or other traumatic event, the Madrell Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed I	:2□No l Bive	ınk "	Vas Deced f Yes, spec	offy Cuban, Me	ic Origin? (S exican, Puerti ecify:	pecify Yes or No- o Rican, etc.)		Race - Amer Black, White ecity: b		
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land	uld be file Mental Hy irked othe	To Be C	17. Father's Name (First, Middle,	Last)				unk 18. 1	Mother's Nan	ne (First, Middle,	Maiden Sur	mame)		unk
Mar	alth and P		19a. Informant's Name/RelationsI Sinai Hospita							nue Balt			p Code) 21215	
aitimore	Pages 1 and of He int: If item		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 X Other (S)		n State	nce of Dispos metery, crem	sition (Nan natory or o	ne of ther place)		Date	20c. Locati	on - City or T	own, State	
Dalt	permit. Departn Imports any inju		21. Signature of Funeral Service Ron 1 d	icensee Vade,	Xx gg	∑St	ate .	d Address of F Anatomy roe, Mi	y Boar	d 655 W.	Balt	imore	Street	
	Physician /Medical		23a. Part . Enter the disease, or shock, or heart failure. List Immediate cause (Final disease or condition resulting in death)	a	each line.	Do not ente	er the mod	e of dying, suc		or respiratory ar	rest,		Approxima Interval Be Onset and	tween Death
g/on,	physician and physician and sthe burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	O (or as a conseque	once of):	PEN	UAL	FA	ILUR	Е			
O. BOX 6	The law requires that the death certific lie has been signed by the atlending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	utcome of pregnan birth 2 Fetal o gnant at time of dea nown	death 3□	Ectopic pr Other (sp				23d.	Date of deliv	_	Year
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VISION OF VITAL	ng Phy fter this ineral o	ation; To Be	25. Was case referred to medical examiner? 1	28a. Date (Mo		R/Outpatient 28b. Time of Injury		Other	☐ Nursing H	th (Check only or ome 5 Resid 28d. Describe h	ence 6 🗆		fy)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could r 4 Homicide determ	ned 289. Plac buil	ce of Injury - At hon ding, etc. (Specify)					28f. Location (S City or Tow	n, State)			nber,
	the Hos thin 24 hc the Fun mpletely f	Medical	29a. Certifier (Check only one) 1 Certifyin 2 Medical (Check only one) 29b. Signature and title of certifier	Examiner: On the	ne best of my know basis of examination nner stated.	neuge, death on and/or inv	estigation,	at the time, da in my opinion . License num	, death occur	rred at the time, o	late and plac	manner as a ce, and due to ce, and d	o the cause(s	s)
	Milw Too		Signature and title of certifier	Was	t									2004
			30. Name and address of person	· 2. P	Isse of death (Item :	MB	Print)	SINA	+1 H	00 105 p1 T	AL	OF 81	YIMOZ	P
	Sta Registr		31. Date fled (Moath, Bay Year)	32.	Registrar's Signatu	re	one d		, •	,		ŕ		

State of Maryland / Department of Health and Mental Hygiene 0014 35800 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ub ewis VOVEMBER /Medical Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SAUTIMORE HVE. Age (In yrs. Jast birthday)
Yrs. 8. Date of Birth (Month, Day, APKIL 9 9. Birthplace (State or Foreign **Funeral** Months Hours JAMAICA Director Usual Residence of Dec the Maryland 10a. State 10b. County 10c. City, 10d. Inside City Limits Town or Location 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No AUTIMOKE Completed by Funeral Director 10g. Citizen of What Country? ō .S.H. or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23, any injury or other traumatic event. If a Meulical Example any injury or other traumatic event. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No f Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working lile. DO NOT use retired) ondary (0-12) Elementary/Se College (1-4or 5+) DOMEST 17 Father Name (First, Middle, Last, r's Name (First, Middle, Maiden Sumame Be RDEL ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BACTO, MD 20a. Method of Disco 1 Burial 2 Cremation 3 Removal from State DACTIMORE, MAKYLAND REMATION/ 11.15.04 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Serv VAUGHT C. GREENE FUNERAL HM. ROAD BAITMARE, NO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dehydration **Physician** /Medical Due to (or as a consequence of) Examiner MEIIITUS DIABETES Sociality list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COVEDYA VASCULAV ACCUDENT 1 Yes 2 No 3 Probably 4 Whitenown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification; To 1 Yes 2 No 4 ☐ Nursing Home 5 ☑ Residence 6 ☐Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 Tyes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Mavy on Mo D35102 November 11 2004 Name and address of person who completed cause of death (Item 23a) (Type, Print) 104 due ROAD Baltimore MANIANO m.D Tunbri 31. Date filed (Month, Day, Year) NOV 1 2 2004 32. Registrar's Signardre State

Registrar

	For State Registrar		State of Ma	aryland /	Departme Certifica	ent of He ate of D	alth and eath		Reg. No.	004	35801
Physician /Medical	61	me (First, Middle, Last) LGENE	Loc	BAN				2. Date of D	Day	2004	3. Time of Death 6:20 PM
Examiner	4a. Facility Name	(If not institution, give s		/·			ocation of Deat	h		ounty of Death	41 F
5	FRANKLII 5. Social Security			e (In yrs. last b			DALE If Under 24 Hrs	8. Date of B		BALTIMO 9. Birtho	
Funeral Director	218-18 Usual Residence	-6044	M 2□F	79	Yrs. Month	ns Days	Hours Min.	8. Date of Bi	25	Ma	elace (State or Foreign etry)
ryland	10a. State	10b. County		10c. City, To	wn or Location			,		1	0d. Inside City Limits
the Marylar 28a-f show notified at	MD			Bal	time	ne					1 Yes 2 No
with the sor 2	10e. Street and N		ette Ro	z d		Zip Code 212 C	260			of What Coun	itry?
5-0036 72 hours after death with the Maryland naturel; or items 23a or 28a-1 show deal Exemple must be notified at shed by Finneral Director	11. Marital Status	Marga	12. Was Decedent Armed Forces?	Ever in U.S.				ipecify Yes or N to Rican, etc.)		Race - Americ Black, White,	
36 satter des	1 Never Ma	arried 2 Married	1 Yes 2 1	No			Specify:	to rican, etc.)		ecify: D	etc.
CLCC Completed by Exercises of it, the Modest Exercise.	3 L Widowed	15. Decedent's Edu	Year or Dates:	16	a. Decedent's U	sual Occupati	on		16b, Kind	of Business/Inc	dustry
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aryla aryla should land Men and Men armerke umatic	19a. Informant's	SON LC Name/Relationship (Ty		Je) 19	b. Mailing Addr	ess (Street an	d Number or Ri	ural Route Numb	er, City or T	own, State, Zip	Code)
Ce, Mg 1 and 2 Health at Health at the 27 is	Glad	45 600	MAS	- 6	0411		weth	erea	d, B	140.N	11 21206
Baltimore, Noemil. Pages 1 and Department of Health Importent: if item 27 minoritent or other than 28 minoritent.	20a. Method of D	isposition 2 Cremation 3 DR	emoval from State	cemet	of Disposition (i			Date	20c. Loca	tion - City or To	wn, State
Baltimol permit. Pages Department of Importent: If it any injury or once.	° 4 ☐Donation	5 ☐ Other (Specify)		(LOW)	usville	Cemete		2-04	Bal	to M	D
Bal permi Depa Impo sny is	21. Signature of	Funeral Service License	L Dree	ne	Jang	and Address	areing	Frue	res	eroice	1212
88.88	23a. Part1. Ente	r the disease, or corpoli eart failure. List only or	cations that caused	the death. Do	not enter the n	nose of ling,	such as cardia	or respiratory a	rrest,	7 96 2	Approximate Interval Between
Physician	Immediate Caus disease or condi	e (Final ition	LUNG		CER						Onset and Death
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68760 cate be physicial the buck			J								
Division of Vital Records, P.O. Box 68 or or attending Physician: The law requires that the death certifical life death. Director: After this certificate has been signed by the attending print by the funeral director, page 2 should be detached for use as the definition of the Completed by Physician/Med	IF FEMALE: 23b. Was deced	ent pregnant 2	3c. If yes, outcome						230	I. Date of delive	ny
death death be atte	in the past 1 ☐ Yes	12 months? 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		th 3∐Ectopii 5∏Other	specify)				Month	Day Year
P.O P.O at the d by the etached	9 Unknov			ust not socializa	in the condest in		in Don't	220 Did	lahassa una	contribute to th	to source of depth?
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of V physic this of al dire	1 ☐ Yes 2	X NO	lospital:		Outpatient 3	DOA Other:	4 Nursing F	fome 5 ☐ Res			<i>'</i>)
On ding l	1 Mariner of De 1 Matural 2 ☐ Accident	5 Pending	28a. Date of Inju (Month, Da	y Year)	Injury	28c. Injury a Work?	ıs 2 ∐No	28d. Describe	now injury o	ccurred	
Division c	3 Suicide	6 ☐ Could not be	28e. Place of Inj	ury - At home, c. (Specify)	farm, street, fac	tory, office		28f. Location	Street and N wn, State)	lumber or Rura	l Route Number,
Divinition or state as all Dirichled in	4 Hollicia		building, et	c. (Spacity)				City of To	wii, State)		
Division of Vital Re To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	29a. Certifier (Check only one)	1 ☑ Certifying Phys 2 ☐ Medical Exami	sician: To the best ner: On the basis of and manner sta	f examination a	ge, death occurr and/or investigat	ed at the time, ion, in my opin	, date and place nion, death occu	e, and due to the irred at the time.	cause(s) an date and pl	d manner as stace, and due to	ated. the cause(s)
To the vithin 2 to the comple		nd title of certifier	and marrier se			29c. License r	number		29d. Date s	igned (Month, I	Day, Year)
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X		ddress of person into co	ompleted cause of d	leath (Item 23a) (Type, Print)		NA 2. 2	1 1 2			12.7.7
	Dr. SABI				0		DRIVE,	BALTIM	IORG	MIDX	123/.
State Registra	6101		Benous	ar's Signature	Spa	KI					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 001 35802 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Marion Shirley Ann Lenhart November 8:25 P. M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mount Airy Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 28, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F 220-74-6442 69 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or itama 23a or 28a-f show traumatic event, the Medical Experiment and the notified at 1 ☐ Yes 2 ☑ No Director Frederick Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zîp Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic average. 4319 Araby Church Road 21704 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Never worked None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Clayton Lenhart, Sr. Edna May Waltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl W. Lenhart/Brother 4319 Araby Church Road, Frederick, MD 21704 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Clustered Spires Cemetery Nov. 9, 2004 Frederick, MD 1 Burial 2 Cremation 3 Removal from State * 4 □Ø nation 5 □ Other (Specify) 21. Sgnalure of Funeral Septice Ligensee 22. Name and Address of Facility
Keeney & Basford Funeral Home M00021 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Apparent to the shock, or heart failure. List only one cause on each line. Mullard Approximate Interval Between Onset and Death Immediate Cause (Final Corga Physician disease or condition resulting in death) 10 45 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate and the sequence of Due to (or as a consequence of): Examine signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b director, page 2 s autopsy performed. 1 ☐ Yes 2 ☐ No 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other Pospice Touse 2**74** No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Al within 24 hours after c 29a. Certifier 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number V 21648 11-8- Jul 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKAT Steel Force to 21161 710 Sa 31. Date file 32. Registrar's Signatur 2004 State Registrar

Angelina Lyamuya Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 7188State of Maryland / Department of Health and Mental Hygiene 0 0 1 UNK 04-361 1 - For State Registrar 35803 AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Angelina Nicholaus Lyamuya Month Day **Physician** November 2004 4:15 P 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Baltimore County Hillsway Avenue & Perring Parkway If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) Funeral Days Min. Months Hours 1 M 2 F 20,1956 TANZANIA Director NIA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No MARVLAND 10g. Citizen of What Country? 10e. Steet and Number 10f. Zip Code AFRICA Items 23e Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: Specify: AFRICAN 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NURS HOSPITAL VRS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental marked 2 HIC Luise KINVAHA NICHOLAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WAY #G 5101 CONANT of Health BALTO, MO. 21206 SON other t MONICA WIL Date (UNICAL) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Importent: If eny injury or once. CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) NZANIA 22. Name and Address Facility BROWN 21. Signature of Funeral Service Licensee . FUNERAL HOME illiamo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Injuries /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Causa (Liseass or injur that initiated events resulting in death) Last Due to (or as a consequence of): -burial-Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ö Day Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 🔀 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2□No 1 Yes 2 \(\text{No} 1**⋉**Xes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ XOther (Specify) at SCENE 1√Xes 2 No L_o 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 11/6/04 16:11 8 1 ☐ Yes 2 🛣 No PEDESTRIAN STRUCK BY CAR (S) 2 Accident Director 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) Hilliam AVC. determined 4 | Homicide ROADWAY AVKVILLE filled MD within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AFIMEdical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

M. Kovell 31. Date liled (Month, Day, Year)

NOV 1 2 2004

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 8, 2004

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygien 2001 35804 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20004 November Barbara Lambert Α. 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8110 West End Drive Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | July 13 1944 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 60 Months 1 ☐ M 2 🛛 F Director 214-54-0930 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 shov s 23a or 28e-1 show 1 ☐ Yes 2 XNo Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8110 West End Drive 21226 USA or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is markad othar than "naturel", or items traumatic avant, the Medical Expedience 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2☐No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ Specify. White 3 YWidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed was and Mental Hygier 7 Is marked other th Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Benway Mildred E. Elberson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is nany injury or othar traun 8110 West End Drive, Balto., Anita Isner (daughter) MD 21226 Date 11 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 2004 Elkridge, Maryland 21. Signature of uneral Service L censes 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications hat cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on eight line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 3 Months /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. cian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) 4 Pregnant at time of death the detached 9☐ Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 20 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death.

Diractor: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel o within 24 hours aft To the Funaral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 39505 Mans who completed cause of death (Item 23a) (Type, Print) Dr. Glen Burnie, Hospi N varkan 305 31. Date filed (Month. 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 00 1 35805 1 - For State Registra Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9,200 ARL MBER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner RANDALLSTOWN BALTIMIRE NORTHWEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F Vrs Director MARYLAND 90 2-23-1914 218-05-1948 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Iteme 23a or 28a-1 ehow any injury or other traumatic event. The Medical Examined Francisco. 1 X Yes 2 ☐ No DC N/A WASHINGTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 USA 1125 EYE ST. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MAILHANDLER POSTAL -0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 ESTELLA HENSON EARLIE LANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1125 EYE ST. WASHINGTON, DC 20002 MILTON LANE (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F
1 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State CROWNSVILLE VETERANS | 11-16-2004 CROWNSVILLE, MARYLAND uneral Sen JUNTHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Enter the disease, or complications that caused the death. shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Phyaician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 99 3 Probably 1 ☐ Yes 2 ☐ No. page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1/Propatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Late of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending 1 Matural after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai within 24 ho To the Fun completely 1 (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NOVEMBER 30. Name and address of of death (Item 23a) (Type, Print) ALTO MOZ1137 NHO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 12 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 35806 Certificate of Death Tty Year 2004 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) LINDER BAUM Day S **Physician** EBECCA overne 2.10AM /Medical 4b. City. Town, or Location of Death
Randallston N 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bottimore Hosp Lel Northwest Months Days Hours Min. 8. Date of Birth APR. 22,1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**V**F 89 215-05-0415 MD Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. r than "naturel", or Itams 23a or 28a-f ehov Ita Medical Examinar must be notified at 1 ☐ Yes 2 🙀 No Directo MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 TIMBERGROVE ROAD 21117 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ad other than "event, IL a Me Elementary/Secondary (0-12) College (1-4or 5+) PHARMACY OWNER permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If Item 27 1e marked otheny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be WOLF RUBIN HOLLAND anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 MAIN STREET - REISTERSTOWN, MD 21136 KAREN FITCHETT / DAUGHTER 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 11/11/2004 REISTERSTOWN, MD 21. Signatury of Funeral Service Liu 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one tause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HORAIC AMEURYGN ACIZIA **Physician** /Medical Due to (or as a consequence of): **Examiner** ATHERO (CLEDNOIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760, by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown نه Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, AKDOMINA AUITIC ANGICALLY 1 TYPES 2 NO 3 Probably DUNKnown Completed 24b. Were autopsy findings available prior to completion of cause of death? ate has b autopsy performed? this certificate 1 TYes 2 No 1 Yes 2 - No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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			19) James 031636			11211011	/
1	\mathbf{r}		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CON J Sware 2/08/13, David Drive U	esk- N	VI 2	1616	
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State of Maryland / Department of Health and Mental Hygiene 2001 35808

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Physician: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	th <i>Check on one</i> ome 5 ☐ Reside		er (Specify)
I or Attending Patter death. Director: After t	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho			
To the Hospital or Attending within 24 hours after death. To tha Funeral Director: After completely filled in by the funer		4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Str City or Town,	, State)		
To the Hospital within 24 hours To tha Funeral completely filled	Medical	(Check only 2 Medical Exem	sician: To the best of my knowledge, dea iner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, da	te and place,	and due to	the cause(s)
To To	2	29b. Signature and title of certifier	And MD.	29c. License number D 3146		d. Date signed	9 (Day, Year)
0			ompleted cause of death (Item 23a) (Type		n'te 308	Ba	lt.n	ND 2120

State Registrar 31. Date filed (Month, Day, Year) NOV 1 2 2004 32. Registrar's Signature

South

55N 214-26-1024

DOB: 10/23/1927

Martin Moore 04--7180 DOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

7 S	180		For Unpend I State Registrar	tem 2	238 ^{tate} .9	f 1 M27	ylanet/	Repe Cei	stgy ent rtificate	1 ^{of} 18 of D	eath Death	M.	ental Hy	giene Reg. No.	00	ł	35809	
	Physici	an	1. Decedent's Name (First, Martin	liddle, La	st)				Moore				2. Date of De Month	ath Day	Ye		3. Time of Death	_
	/Medic Examir		4a. Facility Name (If not insti	ution, giv	e street and nur	nber)			4b. City, T	own, or L	ocation o	f Death	Novemb		200 County of D		-1305 p [™]	_
			2408 East							timo					NA			
00	Funeral Director		5. Social Security Number 214-72-8155		ex Xim 2□F	7. Age (/ 4	In yrs. last l	Yrs.	If Under 1 Months	Year Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)	9.	Birthplac Country	ce (State or Foreign Md.)
	land ow		Usual Residence of Deceder 10a. State 10b. Co			10	Oc. City, To	wn or Lo	cation							10d	. Inside City Limits	_
	death with the Maryland rms 23a or 28a-f show Finust be coeffied at	ctor	Md.	N.	A]	Balt	imore								1 XYes 2 ☐ No	
	with the	Director	10e. Street and Number						10f. Zip (10g. Citize	en of What	Country	/?	
	ier death w	Funeral	2408 E. Fed	eral	12. Was Dece		er in U.S.	13.1	Was Decede	212	panic Orio	in? (Spe	cify Yes or No	- 14	USA 4. Race - A	merican	Indian,	_
036	or Ite	by	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☑ Divo		Armed Fo 1 X es If Yes, Giv Year or D	2 □ No		'	fYes, speci 1□ Yes 2)	y Cuban,	Mexican Specify:	, Puèrto F	Rican, etc.)		Black, W Specify:	/hite, etc $\mathbf{Bl} ilde{c}$	_	
21215-0036	72 hours "natural",	Completed	15. Dec (Specify only h	ident's Ed ighest gra	ducation de completed)		16	(GIVe	dent's Usual kind of work	доле ди	ion ring most	of workin	ig .	16b. Kind	d of Busine	ss/Indus	stry	_
121	filed within 7: I Hygiene. other than "n ant, the Wed	omp	Elementary/Secondary (0- 12th grade	12)	College (1	-4or 5+)			oo NOT use raffit		am			Ral	timor	o Ci	to	
	al Hygie d other want.	Be C	17. Father's Name (First, Mic	dle, Last)					Larre	1	18. Mothe		(First, Middle,			6 01	y	-
Maryland	12 should be filed v h and Mental Hygie 7 Is marked other fraumatic evant, II.	LO.	Johnnie	L		Mod	ore,				Wilm				arter			
Mai	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		19a. Informant's Name/Rela Wilma Moore	ionsnip (Mothe	er							Route Number Baltimo			e, <i>Zip Ci</i> 2121		
Baltimore,	Pages 1 and 2 ent of Health nt: If itam 27 I ry or other tra		20a. Method of Disposition X□ Burial 2 □ Crema 4 □ Donation 5 □ Oth				cemei	tery, crer	sition (Name natory or oth Fores	er place)	1	D:	ate 6 - 04		ation - City		s, Md.	
Balti	permit. Pages 'Department of Himportant: If its any injury or of once.		21. Signature of Euneral Ser	vice Licer	-	2			Name and			'	Balt 1101 E	imor	e, Md	. 2	21202	
N	2		23a. Part1. Enter the diseas shock, or heart failure.	e, or com	plications that	aused the	e death. De	o not ent	er the mode	of dying,	such as	cardiac or	respiratory ar	rest,		A	pproximate iterval Between	
	rnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	ſ	b. ———	orasac	onsequenc	e of):	icieno	y Sy	ndro	me				0	nset and Death	
68760,	icale be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	ĺ	c		onsequenc	,		-								
		a u	IF FEMALE:															
P.O. Box	deatl	Physician/M	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			irth 2 🖯 ant at tim	pregnancy □ Fetal dea ne of death		Ectopic pred Other (spec					23	d. Date of d Month	delivery Da	y Year	
	ires tha signed d be de	by	Part II. Other significent cor	ditions c	ontributing to de	ath but n	ot resulting	in the ur	nderlying cau	ise given	in Part I.				e contribute		cause of death?	
Records,	e law has b	Completed											24a. Was autop perfor	sy	24b. Were prior to death	to compl	r findings available letion of cause of	
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to me examiner?	dical	Magnitali								(Check only o	ne)				_
Division of Vital	ng Phys fter this	ation: To	Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 Accident	nding estigation	28a. Date of (Mont	npatient of Injury h, Day Ye		Outpatien Time of Injury		: Injury a Work?	4 🗀 Nur	28	le 5 ☐ Resid 8d. Describe h			pecify)	at scene	400
Divis	in Diri	Certification:		uld not be termined	20e. Flace	of Injury ng, etc. (S	- At home, Specify)	farm, str	eet, factory,	office		28	8f. Location (S City or Tow	itreet and i	Number or	Rural R	oute Number,	
	the Hospital nin 24 hours a the Funeral I npletely filled	Medical	29a. Certifier 1 ☐ Cer (Check only 2 ☐ Med one)	ifying Ph icel Exen	ysicien: To the niner: On the ba and manr	asis of ex	amination a	ge, death and/or inv	occurred at restigation, in	the time, my opin	, date and nion, death	I place, ar h occurre	nd due to the o	ause(s) ar	nd manner lace, and d	as state	d. e cause(s)	
	To the to the composition of the the the the the the the the the the	Z	29b. Signature and title of ce		mid				29c.	License r					signed (Mo nber	-		
			30. Name and address of pe	son who	completed caus				111		n St	reet,	, Balti	more	, Mary	ylan	d 21201	_
	Sta Registr	_	31. Date filed (Month, Day,)	1 2 ;	2004 32. R	jistrar's	Signature	1 /	book	,								

CPM 04-07275 Amend / Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

1 tem#1, 5,23a, PII, 27, per MEFH C838, 12/18/04 Tr

State of Maryland / Department of Health and Mental Hygiene Cheryl Moseley 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sheryl Lynne Moseley November 10, 2004 16:50 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2153 Belfast Road Apartment G Sparks Glencoe Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 200 Director 50 1954 Maryland April 8, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Directo Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2153 Belfast Road, Apt. G 21152 or Items 23e U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after Armed Forces? 1 ☐ Yes **※**[※]No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXo þ Specify: Specify: 3 Widowed 4 Divorced White 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within in Department of Health and Mental Hygiene Importent; if Item 27 is marked other than "reany injury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Worker Private Caretaking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Moseley Dorothy Ulrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Moseley (Father) 1635 Howard Avenue, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Nov. 12, 2004 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21 Signature of Fu and S rules Literatives once 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Atherosclerotic Cardiovascular Disease dis se or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy to in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 Schizophrenia 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 🗌 No Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1√2 Yes 2 No Other: 2 4 Nursing Home 5 Residence MOther (Specify) SCENE this funeral (28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Naturai 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide n 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 29c. License number My Mine O.C.M.E. November 11, 2004

State Registrar

DHMH 17 Rev 1/2001

NOV 1 2 2004

MARGORIA

31. Date filed (Month, Day, Year)

32. egistrar's Signature

KOROW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

17

				For State Registrer	State of M	Naryland / De <i>C</i>	partment ertificate	of Health and of Death		ene 0 0	35811
_		Physicia		Decedent's Name (First, Middle Ronald Megenha:					2. Date of Death Month October	Day	Year 04 7:11 AMM
		/Medic Examin	7 "	4a. Facility Name (If not institution,		r)	4b. City, To	own, or Location of Dea		4c. County	
		unaval		Joseph Richey 5. Social Security Number		Age (In yrs. last birthd		Baltimore Year If Under 24 Hrs	5. 8. Date of Birth		9 Birthplace (State or Foreign
		uneral irector		216-34-1287	1 ⊠ M 2□F	66 Yrs	Months	Days Hours Min	8. Date of Birth (Month, Day, Jan 20,	1938	9. Birthplace (State or Foreign Country) unk
	yland	MOI TE		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
	не Маг	Ba-f st	ector	MD		Balti		<u>-</u>			1▼ Yes 2 No
	death with the Maryland	3e or 2	i Dire	10e. Street and Number 3121 Elliott S	treet		10f. Zip C	21224	10	g. Citizen of W US	
		tams 2	Funeral Director	11. Marital Status u:	nk 12. Was Deceder	nt Ever in U.S. 1	3. Was Decede If Yes, specif	nt of Hispanic Origin? (S y Cuban, Mexican, Puer	Specify Yes or No- no Rican, etc.)	14. Race	- American Indian, c, White, etc.
	5-0036 72 hours after	"neturel", or itams 23e or 28e-f show adical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	l unk	1 ☐ Yes 2)			Specify:	
		"netur	Completed	15. Decedent' (Specify only highes	s Education grade completed)	16a. De	ecedent's Usual ive kind of work	Occupation done during most of wo retired)	unk 10	5b. Kind of Bus	siness/Industry unk
	2121	r than Tra Ms	omo	Elementary/Secondary (0-12) unk	College (1-40)	r 5+)	e. DO NOT use	retired)			
	pue lie	event,	Be	17. Father's Name (First, Middle, L	ast)		un	k 18. Mother's Na	me (First, Middle, Ma	aiden Sumame	unk unk
	Maryland 21215-0036 nd 2 should be filed within 72 hours aff	Important: If item 27 is marked other than eny injury or other treumstic event, the Magnes.	P	19a. Informant's Name/Relationsh				Street and Number or R			State, Zip Code)
15	e, M	am 27 I ther tre		Joseph Richey 20a. Method of Disposition	/ Hospice	83 20b. Place of Dis		Street Bal			
#	altimore,	nt: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (Sp	3 □Removal from Stat	e cemetery, o	crematory or oth	er place)	Date	oc. Location - (City or Town, State
-	Balti Dermit.	Importa eny inju once.		21. Signature of Europeal Service S			State A	Address of Facility nationy Boar	d 655 W. 1	Baltimo	ore Street
1		2 5 0		23a. Part1. Exter the disease, of	complications that cause	ed the death. Do not		re, MD 212 of dying, such as cardia		it,	Approximate
		sician		shock, or yeart failure. List of immediate Cause (Final disease or condition	- 1	1 1	tive ou	Imonary o	disease		Interval Between Onset and Death
4		edical iminer		resulting in death)	Due to (or a	s a consequence of):		/			1.00-07 7
10	, De	sit	iner	Sequentially list conditions, in the sequentially list conditions, in the sequential sequential sequentially list cause (Disease or injury	b. Due to for a	s a consequence of					10
1/2), execute	physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence of):					
1	8760 cate be e	ohysicia the bur	dicai		d						
¥	Box 68	anding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		0.05			23d. Date	of delivery
10	. ö	signed by the attending p d be detached for use as i	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			3 □Ectopic preg 5 □ Other (spec			Mon	th Day Year
ha	S, P.O	ned by e detac	by Ph	Part II. Other significant condition	1.	· A -	e underlying cau	se given in Part I.	23e. Did toba	cco use contri	bute to the cause of death?
gen	ecords,	been sig	eted t	Coronary arte	y disease	, cardi	omyop	athy	1 ☐ Yes	2 □ No :	3 Probably 4 Onknown
92	Rec The law	age 2 s	Completed						24a. Was an autopsy performe	ed? pr	fere autopsy findings available ior to completion of cause of path?
3	Vital	ertifical actor, p	Be C	25. Was case referred to medical examiner?					1 ☐ Yes 2 dath (Check only one)		□Yes 2□No
	of Vita	ar this c	n: To	1 Yes 2 No	Hospital: 1 ☐ Inpat 28a. Date of In	jury 28b. Time	tient 3 DOA	Other: 4 Nursing H b. Injury at Work?	Home 5 Resident		100
D	Division For Attending	or: Afte	cation	1 Natural 5 Pending 2 Accident investig. 3 Suicide 6 Could n	ation		М	1 ☐ Yes 2 ☐ No			
na	Division Att	d in by	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 286. Place of II	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, o	office	28f. Location (Stre City or Town,		r or Rural Route Number,
8	Hospital or	To the Funerel Diractor: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the bes xaminer: On the basis and manners	of examination and/or	eath occurred at investigation, in	the time, date and place my opinion, death occu	e, and due to the cau urred at the time, date	se(s) and man and place, ar	ner as stated. nd due to the cause(s)
	To the	To the comple	Med	29b. Signature and title of certifier	and manner s	mateu.		License number		-	(Month, Day, Year)
				\$ 50 M	D			D24170	0	ctober	29, 2004
				30. Name and address of person v	his completed cause of Richey Hos	pice 838	NEW	D24170 tawst B	altimore	MD :	21201
	Ser Ser	Sta Registra		31. Date filed (Month, Day, Year) NOV 1 2 200	32. Regis	trar's Signature	Sporks	/			

			For State Registrar	State of M	laryland / Depa Ce	artment of H		,	giene Reg. No. 2 N	01.	25010
	Physici /Medic		Decedent's Name (First, Middle)	Helen E.				2. Date of De		Year	3. Time of Seath 2
	Examin		4a. Facility Name (If not institution, 616 Kingstor	n Road		1	lle Riv	er	4c. County Bal	of Death	
	Funeral Director		5. Social Security Number 218-46-5978 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2√2 F	ge (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1947	9. Birthp Coun Mar	lace (State or Foreign try) yland
	a-f show	ctor	10a. State 10b. County MD Balti	imore	10c. City, Town or Lo	Middle	River			1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23a or 28	al Director	10e. Street and Number 616 Kingstor	n Road		10f. Zip Code 2122	0		10g. Citizen of V	Vhat Coun	try?
980	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jical Evantiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 XVidowed 4 Divorced	12. Was Deceder Armed Forces ed 1 Yes 2 If Yes, Give Year or Dates	₹No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 21 No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		e - Americ k, White, Whit	etc.
21215-0036	c 2 00	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th		(5+) /ife.	dent's Usual Occupi kind of work done of DO NOT use relired ity Con	1)	orking	16b. Kind of Bu		•
Maryland	should be filed within and Mental Hygiene. s marked other than umatic evant, Ins M	To Be (17. Father's Name (First, Middle, I Thomas Ship	i e				_{ame (First, Middle)} abeth W		re)	
	nd 2 :		19a. Informant's Name/Relationsh DAniel L. Mor			ng Address <i>(Str</i> eet a					Code)
Baltimore,	Pages ent of nt: If ii		20a. Method of Disposition 1 Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp			osition (Name of matory or other place Cemeter	^{э)} 11	Date / 12/04	20c. Location - Baltín		
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service L	y Cour	elly	300 Mag	ce Ave.	. Balti	more MI		eofEssex 221
8760,	The law requires that the death certificate be executed XA is the has been signed by the attending physician and injection and injection as the burial-transit in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection injection injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in injection injection in injection in injection in injection in injection in injection in injection in injection in injection in injection in i	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. List of darking Cause (Disease or injury that intilated events resulting in death) Last	a	s a consequence bt):	\	nor				Approximate Interval Between Onset and Death Sylvan Sylvan Sylvan Sylvan Sylvan
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat Mor	e of delive	ry Day Year
Δ.	w requires that been signed by should be deta	by	Part II. Other significant conditio	ns contributing to death	but not resulting in the u	nderlying cause give	en in Part I.			ribute to th	e cause of death? ably 4 Minknown
al Records,		Completed						24a. Was autor perfo 1 \(\text{Yes} \)	osy p rmed? d	rior to con leath?	osy findings available inpletion of cause of 2011 No
f Vital	ys dir	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	tient 2 ER/Outpatier	nt 3 DOA Othe	or	eath <i>(Check only c</i> Home 5 % esid		er (Specify	·)
Division of	Jing Pt J. After th funeral	Certification;	27. Manner of Death 1 Natural 5 Pending investig 2 Accident 3 Suicide 6 Could n	ation ot be 28e. Place of I	njury - At home, farm, sti	M 1□	/ at k? Yes 2 □ No	28f. Location (how injury occurr		Route Number,
Ď	spital or A ours after haral Dirac filled in by		4 Homicide 4 Homicide 29a. Certifier 1 Gertifying		etc. (Specify)	h occurred at the tim	ne, date and place	City or Tou		oner as st	ated
	To the Hospital or Attand within 24 hours after death To the Funaral Director: completely filled in by the	Medical			of examination and/or in		pinion, death occ	curred at the time,		and due to	the cause(s)
	<i>\$</i>		•	$\int \int \int \int \int \int \int \int \int \int \int \int \int \int \int \int \int \int \int $		042	736		11-1	1-01	4
	/0			yno completed cause of	death (Item 23a) (Type.	Print) USON, M	0 2/204	4			
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 2 2	004 Regis	death (Item 23a) (Type. #4// Tew trar's Signature	de .					

State of Maryland / Department of Health and Mental Hygiene 00 4 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MOSORJAK NOVEMBER 11, 2004 3:00 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10319 MALCOLM CIRCLE APT. Α COCKEYSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 3/28/1917 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F 87 Director PENNSYLVANIA 196-07-7249 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Exertiner trust be notified at 1 ☐ Yes 2 No Directo BALTIMORE COCKEYSVILLE ME 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a 10319 MALCOLM CIRCLE APT. death Funeral 21030 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No WWII Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: WHITE Specify: þ 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SOCIAL SECURITY 2 YEARS (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event. Elementary/Secondary (0-12) SUPERVISOR ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN MOSORJAK ANNA BEARJAR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21030 E 10319 NALCOLM CIRCLE

20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State MARY MOSORJAK WIFE MD 20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEM. 11/15/2004 PARKVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee .110 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privsician BLADDER CANCER BWONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit executed Due to (or as a consequence of): attending physician for use as the buria Box 68760 pe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be) FUNGUT IA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 1NO Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending P after death. I Director: After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 4 D47945 NOU II ino 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) ALGEN 7505 HARIS MD DAIVE TOWNER 32 Agristrar's Agriature State Registrar

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Physi		1. [Decedent's Name (First, Middle, Last) MARY E. MAYS	-				2. Date of Death Month 11/	05 / 2004 ear	3. Time of Death 1404 M
/Med Exam		4a.	Facility Name (If not institution, give str	eet and number)	4	b. City, Town, or Loca	ation of Death		4c. County of Death	
•				eral Hosp	Dital.	OCLAN If Under 1 Year If U	Under 24 Hrs	(8)	Worce	ster.
Funera Directo			Social Security Number 6. Sex	7. Age (In yrs.			ours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth	place (State or Foreign
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fter de	Fune	11.	Marital Status 12	. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No		s Decedent of Hispan es, specify Cuban, Mo	nic Origin? (Spec exican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Ameri Black, White,	
Ind 21215-0036 be filed within 72 hours after death with the Maryland ital hygiene. Indicate than "natural", or Items 23a or 28a-f show evant, the Modical Executation in the Modical Executation.	þ		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			pecify:		Specify: W	hite.
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Maryland id 2 should be file the and Mental Hy 27 is marked oth	2	19	a. Informant's Name/Relationship (Type	chaetter		Address (Street and N	Vumber or Rural	Route Number, O	Dity or Town, State, Zij	. Code)
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Baltimore, permit. Pages 1 a Department of Hes mportant: If item		208	a. Method of Disposition 1		Place of Dispositi cemetery, cremat	on (Name of ory or other place)	Da	ite 20	oc. Location - City or To	own, State
Baltimo permit. Pag Department Important: I		-	4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licansee	Itan	kuand	Concidency lame and Address of	11-9-	-04.	PARKUITE	MID
Depart Department	SIICE	-1	Kinberly ().	A Motor	FUA	A) FIZZZO			ROO HARF	
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// /Medica Examine	_	100		Due to (or as a conseq	uence of):					
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K 68 entifica ling ph		IF	FEMALE:							
Box 68 death certifica e attending ph	Physician/Med	23	b. Was decedent pregnant in the past 12 months?	 If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 	ldeath 3 ⊟Ed	etopic pregnancy ther (specify)			23d. Date of deliver	ery Day Year
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ecords, P.O. law requires that the as been signed by th 2 should be detache	þ	Pai	t II. Other significant conditions contr	ibuting to death but not res	ulting in the unde	arlying cause given in	Part I.		cco use contribute to t	he cause of death?
Records, The law requires to the has been signed age 2 should be compared.	Completed							24a. Was an	24b. Were auto	ppsy findings available
G 8 4 6 8	omo	-						autopsy performe	death?	mpletion of cause of 2□ No
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Division alor Attending after death. Director: After din by the fune	Certification:		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street	, factory, office	28	Bf. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
Hospita 4 hours Funeral ely filled	edical Co	29		cian: To the best of my known: On the basis of examination and manner stated.						
To the I within 2 To the I	Me		b. Signature and title of certifier			29c. License nun			I. Date signed (Month,	Day, Year)
			Poly all	٠.		D2910	08	1	1/2/04	
1	2		Name and address of person who com				102 ST	-, SA WIS	BURY MD	21804
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State of Maryland / Department of Health and Mental Hygiene 0 35815 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 3. Time of Death Physician McCann Grace Elaine November 2004 8:30 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie 1504 Eastway Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 12–23–1931 Birthplece (State or Foreign Country)
 PA **Funeral** 1 □ M 2 F 72 218-28-6401 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ö 1504 Eastway 21060 or Items 23a USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ₺ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Grocery clerical work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edna Irene Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan I. Zill/daughter 507 Norman Ave. Glen Burnie MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ortant: If Its 11-11-2004 1 N Burial 2 □ Cremation 3 □ Removal from State Nichols Bethel Cemetery Odenton. 4 □Donation 5 □ Other (Specify) permit. 21. Signature o Funeral Service Cense 22. Name and Address of Facility Depar Impor any n Singleton Funeral Home M01364 Second Ave SW Glen Burnie MD 21061 ci las Part : Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed 68760, detached for use as the attending Box IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Ental death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should be 1 🕅 Yes 2 🗆 No 3 Probably 4 Unknown been 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has performe certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury within 24 hours after death. To the Funeral Director: A 1 Tyes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗌 Homicide To the Hospital Medical Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 204 GlenBurNIE MD. 21061 RD. 78450AKWOOD UR SHOBHA D. RENDI 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrar 35816 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 12:30 P.M. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BURNIE AnneArundel 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Y Aug. 27, 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F 50 219 64 9224 Yrs. Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If item 27 ie markad other then "naturel", or items 23a or 28e-f ehow 10a. State 10b. County 10c. City, Town or Location 7 ie markad other then "naturel", or items 23a or 28e-f ehow traumatic event. Inc Medical Examiner must be notified at 10d. Inside City Limits Maryland Anne Arundel 1 ☐ Yes 2 XNo Director Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Longwood Avenue 21061 U.S. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Moore Margaret Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Teresa Friel / 4033 - 6th Street Baltimore, Maryland 21225 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State perrit. Page Department o Importent: if any injury or once. ö Bayview Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 11/9/2004 Baltimore, Maryland 21. Sign wre of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 neste 23a. Part1. Enter the disease or shock, or heart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ARREST /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed YPERLIPIDEMIA Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Endometrial 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Anxiet 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a

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completely filled † Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton MD Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 35817 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9, November Flora Carrie Merson 2004 9:37 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep 22, Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 X F 77 Yrs. Sep 1927 Director 219-22-7100 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28e-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 United States 1213 Chipper Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after of Mental Hygiene. marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ 3 UVidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry General Elementary/Secondary (0-12) College (1-4or 5+) Painter other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Howard Lloyd Lillian M. Lugenbeel 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randolph R. Merson/Husband 1213 Chipper Drive, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov 10 1 Burial 2 Cremation 3 Removal from State Beltsville, MD Chesapeake Crematory 2004 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Cremation and Funeral Alternatives MO0986 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mutastance Colon disease or condition resulting in death) Year) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit Due to (or as a consequence of): physician Physician/Medical the attending Вох IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗆 No 1 Yes 2 2 No 1 🗌 Yas Physicien: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 1 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury curred After Injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation within 24 hours after deati To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signafure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2 M 31 Date filed (KOO) 32, Registrar's Signature State Registrar

MIBRON FLORA 11 09/04/04/02

State of Maryland / Department of Health and Mental Hygienes For State Registrar 35818 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 2004 12:30P M /Medical Vivian Catherine Norris 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville Baltimore 15 Holland Hill Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Yrs. 79 Director June 27,1925 212-22-3605 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f shoy Maryland Baltimore Catonsville 1 ☐ Yes 2√2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21228 United States 15 Holland Hill Court by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper/ account supervisor department store 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Olver Grace Yeager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Erlington Drive, Cinnaminson, New Jersey 08088 John Price – nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Loudon Park Cemetery 11/11/2004 21. Signature of Funeral Service Licer see 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MONTHS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Records, P.O. Box 68760 by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HU (EWS) ON 3 🗀 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed MENTIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 24a. Was an Jas autopsy performed? Yes 2 No certificate 1 ☐ Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death

1 Natural
2 Accident after death. I Director: After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DOU 5845+ NOVEMBER 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 82 BATIMORE MOZIZOI NATIONA EASAR NORTH LUTAW 31. Date filed (Meath 2 2004 32. Registrar's Signature State Registrar

ORIGINAL

		Department of Health and Mental Hygi Certificate of Death	•
Physiciar /Medica Examine	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Day Yeer 3:30 ρ M 4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bir 215-90-1753 1 □ M 2 □ XF 41 Usual Residence of Decedent	rthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Yrs. Days Hours Min. Aug. 1	Pathmore 9. Birthplace (State or Foreign Country) Maryland
death with the Maryland ms 23a or 28a-f show Linual be notified at	10a. State 10b. County 10c. City, Tow Baltimore 10c. Street and Number	Dundalk	10d. Inside City Limits 1 Tyes 2X No
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P	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 Maryland 21215-0036 ad 2 should be filed within 72 hours att the and Mental Hygiene. 77 Is marked other then "natural; or traumatic event, the Mudical Exert To Re Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Ma	(Give kind of work done during most of working	6b. Kind of Business/Industry Northorp GrumanCo.
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Mary Mary Mary Mary Mary Mary Mary Mary	19a. Informant's Name/Relationship (Type, Print)	o. Mailing Address (Street and Number or Rural Route Number, 3468 McShane Way Baltimo	
Mattershall Baltimore, Mapernii. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other treu	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	f Disposition (Name of ry, grematory or other place) adHeartofJesus11/10/04 B.	Oc. Location - City or Town, State altimore MD
Balti Permit. Departm Importa any inju once.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Connelly Fu 300 Mace Ave. Baltimor	neralHomeofEssex
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Box 68760, eath certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner	d	of):	
Division of Vital Records, P.O. Box 68 To the Hospital or Attanding Physician: The law requires that the death certifical within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
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To th withir To th comp			1. Date signed (Month, Day, Year)
o_i	30. Name and address of person who completed cause of death (Item 23a) ((Type, Print) In Square Drive Baltimore	ovember 6,2004
State Registrar	31. Date filed (Month, Day, Year) NOV 1 2. 2004 32. Registrar's Signature	in Square Drive Baltimore	2,m0 31231

DHMH 17 Rev 1/2001

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			For State Registrar	State of Ma	ryland / D	epartmei <i>Certifica</i>	nt of Heal	lth and M <i>ath</i>		ene 200L	35820
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030	d within 72 hours after death with the Marylan piene. r than "natural", or Items 23a or 28a-1 show the Madical Examiner must be multified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ∰Yes 2 □ N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 \(\superscript{\text{Yes}}\)		ic Origin? (Spe exican, Puerto F ecify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
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N I G	Attending Physician: The death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other		(Check only one)		
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	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fu	edicai (29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Example 1	ysician: To the best of tiner: On the basis of and manner stat	examination and	death occurred Vor investigation	at the time, da , in my opinion	ite and place, a , death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
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	')		30. Name and address of person who carry Koeni	completed cause of de	ath (Item 23a) (Type, Print) Universi	ty Pkwy	r, Balti	more, M.	aryland	
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Physician	
/Medical	
Examiner	

1 - For State Registrer

Cyrus

J.

Phillips

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Funeral		5. Social Security N	lumber 6. Ş	ex 7. Ag	ge (In yrs. last birt	hday)	If Under 1 Year	If Under 24 Hr		th	9. Bi	rthplace (State or Foreign country)
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2 should be filed within 72 hours after death with the Maryland and Membal Hygiene. I and Membal Hygiene is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examinal must be notified at	Funeral Director	11. Marital Status	17	12. Was Decedent Amed Forces?		13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (ın, Mexican, Pue	Specify Yes or No rto Rican, etc.)	-	14. Race - Am Black, Whi	
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and 1			ame/Relationship (g Address (Street a					
alth a		Helen G.	Phillips	s/ Wife	26	576	Compass 1	Drive, A	nnapolis	, Ma	aryland	21401
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To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Me	29b. Signature	title of certifier	A A			29c. License	number		29d. Dat	te signed (Mont	th, Day, Year)
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

WDW 1 2 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9.00 /

			1 - For State Registrar		State of Ivial	yland / De C	ertificate of	Death		Reg. No.	35822
	Physic /Medi		1. Decedent's Name (First, William	1	rguson	fear	e, Jr.		2. Date of Dea Month Novel	ith Day Yea	3. Time of Death
	Examir		4a. Facility Name (If not inst	Cen	ter	To some to an hindhold	Ton	SON If Under 24 Hrs.		Balti	more Co.
	Funeral Director		215-56-74 Usual Residence of Decede	//	M 2□F .Age (In yrs. last birthda Yrs.	Months Days		8. Date of Birth Manth, Day July 2	2,1951 B	Sirthplace (State or Foreign Country)
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	ath with th	Funeral Director		ervai				1204		10g. Citizen of What	Country?
9:00-9	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumatic event, Ira Madical Exemires must be notified at	by	11. Marital Status 1 Never Married 2 3 Widowed 4 Divi		12. Was Decedent Ev Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates:	er in U.S. 1	3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, W Specify: (merican Indian, hite, etc. Vhrte
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21	filed within Hygiene. other then "gent, Ir a Mac	Com	17. Father's Name (First, Mi		College (1-4or 5+)	Bi	rd Dog	Traine	20		raining
land	iould be f I Mental H harkad ot hatic ever	To Be	William F		uson PE	arce,	Sr.	Mary	e (First, Middle, I	Maiden Sumame) Ng	
Maryland	d 2 sho th and N 7 Is ma trauma		19a. Informant's Name/Rela	tionsh (T)	CILLERING	4 - 1 9b. Ma		// ~	2/1	City or Town, State	, Zip Code) D. 21401
- 10	es 1 and of Health fitam 27 rother tu		20a. Method of Disposition 1 Burial 2 Crema	#109 3 🗆 (SKINNER	20b. Place of Dis	position (Name of rematory or other, pla	e D(- 1	Tunap.	20c. Location - City	
Baltimore	permit. Page Department o Important: If any injury or once.		'4 □Donation 5 □ Oth	er (Specity)	2	Evans Fu		eel IVOV.	10,2009	Forest	Hill, MD.
Ba	permit. Departr imports any inje		1011		11	A. 1	eace full	OCK RA	gatives Time	s funeral	+ Cremation CX
			23a. Flant / Enter the diseas shock, or heart failure.	e, or comp List only o	lications that caused the ne cause on each line.	e death. Do not e	enter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	-	a. Metess Due to (or as a c	1110	Nan-sn	iell cell	Cing (Cana	moritus
	Examiner	ler	Goquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	H	Due to (or as a c	onsequence of):					
15	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c. Due to (or as a c						
68760,	rtificate be executed ng physician and as the burial-transit				d	onsequence or).					
		/Medical	IF FEMALE:		23c. If yes, outcome of	oregnancy					
.O. Box	The law requires that the death cer Ite has been signed by the attendir bage 2 should be detached for use	Physiclan/	23b. Was decedent pregnation the past 12 months? 1 Yes 2 No 9 Unknown	11	1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	☐Fetal death 3	B Ectopic pregnancy Other (specify)	<i>'</i>		23d. Date of d Month	elivery Day Year
Records, P.	w requires that been signed t should be det	by	Part II. Other significant co	nditions co	ntributing to death but r	not resulting in the	underlying cause giv	ren in Part I.	23e. Did tot		to the cause of death? Probably 4 Unknown
al Reco	(O LL	Completed							24a. Was a autops perform 1 Yes 2	v prior to	autopsy findings available completion of cause of second No.
Vital	Physiclan: Th this certificate ral director, pag	To Be	25. Was case referred to me examiner? 1 \sum Yes 2 \sum No	-	fospital:	2 ☐ ER/Outpati	ent 3 DOA	26. Place of Deatler:	h (Check only on me 5 ☐ Reside	V .	aciful A civolar
on of	ding Physiclan: h. After this certific funeral director,			ending	28a. Date of Injury (Month, Day Y	28b. Time	of 28c. Injur	y at k?		w injury occurred	outly to the
Division	or Attenter ter deatiractor:	Certification;	3 ☐ Suicide 6 ☐ C	vestigation ould not be etermined	28e. Place of Injury building, etc. (- At home, farm, s Specify)		Yes 2 □ No	28f. Location (Sti City or Town	reet and Number or F 1, State)	Rural Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier Check only one)	tifying Phy lical Exami	sician: To the best of ner: On the basis of example and manner stated	amination and/or	ath occurred at the tir investigation, in my o	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of ce	rtifier	0		29c. Licens	e number		9d. Date signed (Mor	
			30 Name		Curry	h //s 00: 1 =	US	8303	/	Jovember	mo 21204
	7		30. Name and address of pe	CHAN	LES W	> 660	(N.CI	revies S	+ Bo	ultimere	mo) zizoy
	Sta Registr		31. Date filed (Month, Day, 1988) NOV 1 2		32. Registrar's	Signature	1				

PEARCE, WILLIAM 1/9

			For State Registrar	State of Marylan	nd / Depa <i>Cer</i>	rtment o tificate	f Health a of Death	ind Menta	al Hygie _{Reg.}	2004	35823
			Decedent's Name (First, Middle, Last)						ite of Death	Day Year	3. Time of Death
	Physicia		GRACE EVELYN PRO	WANT				1		07, 2004	5:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Tow	m, or Location of	f Death		4c. County of Death	
			Howard County Gene	ral Hospital		Colum				Howard	
	Funeral Director		5. Social Security Number 6. Sex 1 □	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 2 ays Hours	Min. (M	te of Birth conth, Day, Ye t 06,	9. Birthp Coun 1928 Virg	lace (State or Foreign stry) inia
	P		Usual Residence of Decedent	140 00							04 (04) (04)
	arylar how	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				I	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Director	MD Howard	La	urel	101 7: 0			10-	. Citizen of What Coun	
	death with the Maryland ms 23a or 28a-f ehow		10e. Street and Number			10f. Zip Coo			"		itty !
	9ath	erai	8719 Susini Drive	2. Was Decedent Ever in U	LS. 13.V	2072	of Hispanic Orig	oin? (Specify Y		S.A.	an Indian.
	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or ttams 23a or 28a-f show event, the Mcdical Examination was be notified at	/ Funerai	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	1	fYes, specify (□ Yes 2)XX	Cuban, Mexican	, Puèrto Rican,	etc.)	Black, White,	
Š	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:					1 400	Specify: White	
2	I be filed within 72 h ntal Hygiene. ed other than "natu event, the Medical	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual O kind of work do OO NOT use re	ccupation one during most stired)	of working	16	b. Kind of Business/Ind	dustry
Z	withir ene. then	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	Homer		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Own Home	
מ	filed Hygi other		17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First	, Middle, Mai	iden Sumame)	
Maryland 21215-0036	should be and Mental I smarked o	To Be	Kenneth DePew				Dora	Ann Jo	nes		
az	s 1 and 2 should of Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	g Address (St	reet and Numbe	r or Rural Rout	e Number, C	ity or Town, State, Zip	Code)
	1 and 2 Health a tem 27 ts		Carol McMillion /					, Dunda	ılk, Ma	aryland 212	222
≂			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, crem	sition (Name of natory or other	place)	Date	200	c. Location - City or To	own, State
Ĕ	Pages ment of I ant: If It ury or o		`4 ☐Donation 5 ☐ Other (Specify)	Li			1 Cem N			larksville	, Maryland
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Fundral Service License	M007	7.2 Z2	Name and A DONALDS	ddress of Facility On Fune	ral Hom	ne, P.A	A. aryland 207	707-4389
			23a. Part1. Enter the disease, or complic	ations that caused the dea							Approximate Interval Between
	Pnysician		shock, or heart failure. List only on Immediate Cause (Final	Myocardial	Inform	tion					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec		CIOII					Acute
	Examiner		Sequentially list conditions b.								
	р ц	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):						
	icate be executed physician and s the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	nuence of):						
8760,	be ex ician burial	E E		500 10 (01 23 2 0011300	quanta ory.						
387	phys phys s the	dicai	d								
×	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregn						23d. Date of delive	эгу
. Box	death e atter	iciai	in the past 12 months?	1 Live birth 2 Feta		Ectopic pregn Other (specif				Month	Day Year
P.O.	that the de led by the a detached t	hys	9 Unknown	9□ Unknown							
S,	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	by Physician/Me	Part II. Other significant conditions con Coronary Artery	•	sulting in the u	nderlying caus	e given in Part I.	2		co use contribute to th	ne cause of death?
0.0	w requires to been signer should be a	etec						_			
Rec	has has	Completed	Diabetes Mellitu	15					4a. Was an autopsy performed	prior to cod death?	psy findings available impletion of cause of
ta		0	25. Was case referred to medical				26. Place	of Death (Che	☐ Yes 2☐ ck only one)	(No 1 ☐ Yes	2U N0
>	Physician: this certifica ral director, p	To B	examiner? 1 Yes 2 XNo	ospital: 1 ☐ Inpatient 2X	ER/Outpatier	t 3 DOA	Other			e 6 Other (Specify	y)
0	Attending Physician: If death. Cotor: After this certific by the funeral director.	L:u	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?	28d. D	escribe how	injury occurred	
Ö	uttendin death. ctor: Af y the fur	atic	1 XXNatural 5 Pending 2 Accident investigation			М	1 ☐ Yes 2 ☐ N	No			
=	2 = = =	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory, of	fice	28f. Lo	cation (Stree ity or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin							
	the the trible	Med	29b. Signature and title of certifier	and manner stated.		29c. Li	cense number		29d.	. Date signed (Month,	Day, Year)
	£ ₹ 8		1 1 / la la				4997			November 9	
1	Ω		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Tvpa						
	10		Luis A. Casas, M.I	8317 Cher			el, Mar	yland 2	20707		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	Ature And	2					

State of Maryland / Department of Health and Mental Hygiene 004 35824 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 12:23 A^M **JEANNETTE** В. **POORBAUGH** 7, 2004 November /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 14500 Bowie Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept 1, Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2√₹ Vre 220-10-4976 94 PA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State worle or than "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1.☐Yes 2 ☐ No Director MD Prince George's Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14500 Bowie Road 20708 U.S.A. Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grade Education Secretary Peges 1 and 2 should be filed viment of Health and Mental Hygie tant: If Item 27 le marked other toury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bessie A. Blankney William G. Bishop 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeanne Skidmore / Daughter 14500 Bowie Road Laurel, Maryland 20708 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 XX emoval from State permit. Pege Department of Important: If eny injury or * 4 □ Donation 5 □ Other (Specify) Everett Cemetery 11/11/2004 Everett, PA 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 45 313 Talbott Avenue, Laurel, MD 20707 / M00770 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List pnly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** l year Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last ng physician ar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: esn nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ò in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown Rheumatoid Arthritis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 certificate 1 ☐ Yes 2 No Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 3 DOA 2 ER/Outpatient ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide 24 hours a filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D36716 November 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, MD 8317 Cherry Lane, Laurel, MD 20707 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien 1 - State Registra 35825 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 4, REGINALD PITTS 2004 5:31a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RITCHIE HOSPICE BALTIMORE N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 12 M 2□ F Director 218-86-3206 39 Yrs. 2-10-1965 NORTH CAROLINA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23a or 28a-1 show other treumatic event, tre Medical Espainter must be notified at Director 1 ☐ Yes 2 ☐ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 343 S. DALLAS CT. 21231 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No ģ Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) -12-DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mental Importent; If item 27 is marked of any injury or others. 2 should be f and Mental I HARVEY PITTS MILDRED RIVERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY BRAWNER (SISTER) 4800 SIPPLE AVE. BALTIMORE, MARYLAND 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ cremetion 3 ☐ Removal from State ° 4 ☐ Donation 5 Other (Specity) MT. ZION CEMETERY 11-10-2004 BALTIMORE, MARYLAND 21. Signature of Funeral Service Lice MAHTANOL & D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Part / Enter the disease, or complications that caused the death. short, or heart failure. List only one cause on each live. Immediate Cause (Final Priysician disease or condition resulting in death) /Medical ce of): Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death by 4 _ nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 245. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 ZOther (Specify Monn of Datural of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not determine 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the 29b. Signature and 29d. Date signed (Month, Day, Year) State NOV 1 2 2004 Registrar

Meginald

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35826 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Angela Kay Roth NOV. 10. 2004 6:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 923 Rambling Drive Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAY 7, 1952 9. Birthplace (State or Foreign Days 1□M 2X F California Director 569-96-5554 52 Yrs. Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic evant, the Medical Examinant har notified at Director 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 923 Rambling Drive Itams 23a 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itam any injury or other traumatic evant, the Medical Exert Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Database Manager and Elementary/Secondary (0-12) College (1-4or 5+) Software Engineering <u>Technical Document Specialist</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Everett Wren ဂ္ဂ Velda Knoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Todd Roth/husband 923 Rambling Drive Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/12/04 Baltimore, MD Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw nset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide hin 24 hours a 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) within To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 41139 30. Name and address of who completed cause of death (Item 23a) (Type, Print) Clement B. Knight, M.D., 11065 Little Patuxent Parkway Columbia, MD 21044 to filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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	Physici /Medio		Decedent's Name (First, Middle, L	Preston	D. R	exrode		2. Date of De Month Novembe	Day	Year)()(4	3. Time of Death 7:07 A
	Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death		4c. County		- /.U/ A
0			9100 Phildade			Roseda			Balti	more	County
29	Funeral		5. Social Security Number 6. 280-66-9717	5ex 7. Age (In yrs. 1 M 2 □ F 4 4	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Feb. 3	h	9. Birthp	place (State of Foreign ntry)
5	Director		Usual Residence of Decedent	44	170.			reb.3	, 1960	Ohi	LO
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	10d. Inside City Limits
	B-f sh	ctor	MD Balt	imore		Roseda	le				1 ☐ Yes 2√2 No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Nhat Cour	ntry?
	ath w	Funeral Director	9100 Philidel	-			237		USA		
	er de Items	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac	e - Americ ck, White,	ean Indian, etc.
36	I', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 2€ No	Specify:		Specify	www.whi	ite
9	2 hou	led 1	15. Decedent's	Education		dent's Usual Occup			16b. Kind of Bu	usiness/In	dustry
215	hin 7.	ple	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work done o DO NOT use retired	during most of worki d)	ng			
21	giene giene er th	Completed	11th		Owne	r			Prest	on L	ORywall
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, If a Medical Examinatinast be notified at	Be	17. Father's Name (First, Middle, Las Raymond P. F	•			18. Mother's Name		Maiden Suman Havanas	,	
Ž	hould Me mark matic	To	19a. Informant's Name/Relationship		19h Mailie	og Address (Street	and Number or Rura				Codel
	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		Donna Rexrode				delphia		i, City of Town,	State, Zip	Code)
<u>ē</u>	s 1 ar if Hea item othe		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place)ate 2 / 0 4	20c. Location -	City or To	own, State
Baltimore,	Page ment o ant: If ury or		1 ☐ Burial 2 🙀 Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	Puerinosa inom State Ra	yview	Cremato:	- 1		Balti		
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra ance.		21. Signature of Funeral Service Lic	ensee C	22	. Name and Addres	ss of Facility Cor	nelly	[unera]	LHom	eofEssex
	-		23a. Part1. Enter the disease, or co shock, or heart failure. List on	inplications that caused the death	h. Do not ent	er the mode of dyin	ce Ave. g, such as cardiac c	r respiratory an	nore Mi rest,) 21	Approximate
	Pnysician		Immediate Cause (Final disease or condition	Methadone and	,						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		Inc Incox	ICCCION				
	Examiner	.	Sequentially list conditions.	b							
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
_	xecut and II-tran	хап	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
8760,	rate be executed hysician and the burial-transit	dical E	· ·								
189		edic		u							_
Вох	eath certifi attending for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal		Tatania arangan			23d. Dat	e of delive	ory
	ne death the atte	Physician/Me	in the past 12 months?	4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Mor	nth	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown								
Š	ires tha signed d be del	by	Part II. Other significant conditions	contributing to death but not rest	ulang in the ul	nderlying cause give	en in Part I.			nbute to th 3∏Proba	e cause of death?
Örö	w requir been si should	etec									, <u>1</u>
Records,	has ge 2	Completed						24a. Was a autop:	sv p	rior to con	psy findings available apletion of cause of
	ician: Th certificate ector, pag	မ င်	25. Was case referred to medical					1 Yes		eath? Yes	2□ No
Vital	ysicia is cert directo	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Othe	26. Place of Death				
of	Attending Physician: r death. sctor: After this certific. by the funeral director,	-	27. Manner of Death	28a Date of Injury	28b. Time of	1 JUDON	4 Indisting Hor		ow injury occurr		at scene
jo	ttending I death. stor: After the funer	atlo	1 □ Natural 5 □ Pending 2 □ Accident vinvestigati	on 11-9-04	Found, 6:50	A M 1 D	res 2 X No	Unknown			
Division	r Atte	Certification:	3 Suicide 6 Could not determine	be d 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	et, factory, office	2	28f. Location (S City or Town	treet and Number	or Rura	9100 Number,
Q	ral Di			Found in res	sidenc	e 	P	hiladel	phia Rd	.,Ros	sedale, MD
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying F	Physician: To the best of my know aminer: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cod at the time, d	ause(s) and mar ate and place, a	nner as sta ind due to	ated. the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	- 0	1	29c. License	number	2	9d. Date signed	(Month, I	Day, Year)
			laroett	Illan ma		O.C.M	.E.	N	ovember	10.	2004
			30. Name and address of person who	completed cause of death (Item	23а) (Туре,	·					
	Sta	te-	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture		Street,	Baltimo	re, Mar	yland	1 21201
	Registr		NOV 1 2 2004	General &	Spery	E)					

			1 - For State Registrar	State of I	Maryland /	Depa Cer	artment of Hertificate of L	ealth and Death	l Mental H	lygier		3	35828
			Decedent's Name (First, Middle, L.)	ast)					2. Date of	Death			3. Time of Death
	Physici /Medio		SHARRON MAE RO	RISON					Month NOVEME	Da SER 3		ear	4:00 A. M
	Examin		4a. Facility Name (If not institution, gi		er)		4b. City, Town, or	Location of De			. County of		1.00 11.
			1000 FELL STREET	APT- 62	1		BALTIMO			1	A\N		
	Funeral		,	Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month,	Day, Year)		Birthpla Country	ce (State or Foreign y)
	Director		489-36-3252 Usual Residence of Decedent		69	113.			12/22	2/193	4 1	/ISS	DURI
	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation					100	d. Inside City Limits
	Mar Mar	ţċ	NC CUMBER	LAND	FAYE?	TEV	ILLE						1 ☐ Yes ZX No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of Wha	t Countr	y?
	23a		537 CYPRESS TRAC	E			28314			US	A		
	72 hours after death with the Maryland neturel', or tems 23a or 28a-f show lical Examiliar mast be multified at	Funerai	11. Marital Status	12. Was Decede Armed Force	s?	13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	No-	14. Race - A Black, N	Americar White, et	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2[If Yes, Give Year or Date	4.		1 ☐ Yes 2 ☐ No	Specify:			Specify:	* ** ***	
21215-0036	72 hours neturel',		15. Decedent's 8	ducation			dent's Usual Occupa			16b. K	ind of Busin	WHIT ess/Indu	
215	⊆ -	Completed	(Specify only highest gas Elementary/Secondary (0-12)	rade completed) College (1-4d	or 5+)	(Give life.	kind of work done do DO NOT use retired)	uring most of w	vorking				,
	filed withir Hygiene. other then	Соп	12TH GRADE			PARA	LEGAL			CI	VIL SE	RVI	CE
pu	0 7 5	Be	17. Father's Name (First, Middle, Las	t)					ame (First, Midd	lle, Maiden	Sumame)		
Уlа	should be nd Menta marked matic sv	ဥ	UNAVAILABLE					RHEA					
Maryland	d 2 st th and 7 te n traun		19a. Informant's Name/Relationship WESTON ROBISON				g Address (Street a		Rural Route Nun T. 621 E				ode) 21231
	1 and Heali Iem 2		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of	Ī	Date Date	_	cation - City		
Baltimore,	Pages 1 and 2 should be ment of Health and Mentient: If item 27 te marked iury or other traumatics	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		16		LE MEM. (/7/2004				
alti:	2552		21. Signature of Funeral Service Lice		twip11		. Name and Address			ON FI	ETTEV.	HOM TPPE	, NC E. D A
m	permi Depa Impo any ii		1/				21 LOCH R			WSON,		2128	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caus	ed the death. D	o not ent	er the mode of dying	, such as cardi	ac or respiratory	arrest,			pproximate nterval Between
	Physician		Immediate Cause (Final disease or condition	, Ovav	ian Car	n(ev							and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	e of):							
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or :	as a consequenc	e off:						-	
	uted Insit	min	cause. Enter Underlying Cause (Disease or injury			,-							
Ć.	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or a	as a consequenc	e of):						-	
8760,	te be ysicia ne bur	dicai		d									
9		o l	IF FEMALE:	2									
Вох	death certific e attending p d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea	th 3	Ectopic pregnancy			:	23d. Date of Month	delivery Da	ay Year
0.	0 0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of death	5 🗆	Other (specify)				WORL	D.	iy rear
<u>α</u>	requires that the teen signed by th hould be detache		Part II. Other significant conditions	contributing to death	but not resulting	in the ur	nderfying cause giver	n in Part I.	23e. Dio	tobacco u	ise contribut	e lo the	cause of death?
Records,	uires sign ld be	d by							1 [Yes 2	≥ √No 3[] Probab	ly 4 Unknown
CO	> 40 %	lete							24a. Wa	is an	24h. Were	autoos	y findings available
Re	0 - 0	ompleted							aut	opsy formed?	prior	to comp h?	letion of cause of
Vital	icien: Th certificate ector, pag	e C	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only		10	Yes 2[N0
of V	S I	To B	examiner? 1 ☐ Yes 2 反 (No	Hospital: 1 Inpa	tient 2 ER/0	Dutpatien	t 3 DOA Other	4 Nursing	Home 5 ☐ Re	sidence (SON'S	RES.	IDENCE
	ding Phy h. After thi tuneral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury 28b Da <i>y Year</i>)	. Time of Injury	28c. Injury Work	at ?	28d. Describe				
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation	18				es 2 🗆 No					
Division	P S in the	Certification:	4 Homicide determined	28e. Place of	njury - At home, etc. <i>(Specify)</i>	farm, stre	eet, factory, office			(Street and own, State)		r Rural A	oute Number,
	e Hospitel 24 hours a e Funerel I letely filled		29a. Certifier 1 Certifying P	hysician: To the be	st of my knowled	ge, death	occurred at the time	date and place	ce, and due to th	e cause(s)	and manne	r as state	nd
	e Ho	edicai	(Check only 2 Medical Exa	miner: On the basis and manner	of examination a	and/or inv	estigation, in my opi	nion, death oc	curred at the time	e, date and	place, and	due to th	e cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certilier				29c. License	number		29d. Date	e signed (M	onth, Da	y, Year)
)) July 3				DOC	5355	2	11	13/04		
	10		30. Name and address of person who	completed cause o	f death (Item 23a) (Type, I	Print)						
			ROBERT BRISTOW,		V. WOLFE	ST.	ROOM 28	BAL?	TIMORE,	MD			
	Sta Registr		31. Date filed (Month, Day, Year)	SZ Hegi	strar's Signature		AP.						
211					10	7	Joans 1						

ORIGINAL

			1 - State of Maryland / I	Depa	ertment of Hertificate of L	ealth and N	lental Hy	_	04	35829
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
1	/Medi		RICHARD ELWOOD REEDY, JR.				Novemb	er- 10	2004	3:50m
	Examir	er	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		4b. City, Town, or			4c. Count	y of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	irthday)	If Under 1 Year	ORE CITY If Under 24 Hrs.	8. Date of Bir	th	N/A	lace (State or Foreign
ı	Director		216-40-8619 MDM 2DF 61	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 11/12,	7 1942	NEW	lace (State or Foreign htry) JERSEY
	Pu .		Usual Residence of Decedent				, ,			
	shov	5	10a. State 10b. County 10c. City, Tow MD BALTIMORE PARK						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	288-1	rect	10e. Street and Number	. V . I. I.	10f. Zip Code			10g. Citizen of	What Coun	
	3a or	0	7915 WESTMORELAND AVENUE		21234	4		USA	Wilat Cour	itty:
>	death	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	13. W	Vas Decedent of His Yes, specify Cubar		ecify Yes or No	- 14. Ra	ce - Americ	
21215-0036	within 72 hours atter death with the Maryland ane. then "natural; or Items 23a or 28e-1 show the Madical Expr. ther mat be notified at	þ	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No tf Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	j	Yes, specify Cubar ☐ Yes 2 🛣 No		Hican, etc.)	Specia	ick, White, of fy: WH]	etc. LTE
50	d within 72 ho piene. r then "natu	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	(Give k	ent's Usual Occupation	uring most of work	ing	16b. Kind of B	Business/Inc	dustry
12	within	du	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT use retired)			BTD= 40.	4C =114	
	be tiled vital Hygie of other levent, to		12TH GRADE O	WNEF	R-INSTRUC	LOR 18. Mother's Name	a (First Middle			STRUCTION
au	9 5 5 5	To Be	RICHARD ELWOOD REEDY, SR.				J SKARZY		,	
Maryland	d 2 should th and Mer 7 is marke traumatic	-			g Address (Street a			er, City or Town	, State, Zip	Code)
	and 2 ealth m 27 i				WESTMORE			JTIMORE,		21234
Baltimore,	Pages 1 and nent of Heall snt: If item 2 ary or other		1 Burial 2 Cremation 3 Removal from State	ery, crem	sition (Name of latory or other place)	Date	20c. Location	-	
Ē	t. Pa rtmen rtent: njury		' 4 □ Donation 5 □ Other (Specify) METRO 21. Signature of Funeral Service Licensee		EMATORY, I	-		CATONS		
Ba	Depa Depa Impo any ir		M. Heal Colones		Name and Address	1110			RAL HO 2128	OME, P.A.
			23a. Part1. Eafer the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	or the mode of dying	, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Chronic Obst Due to (or as a consequence	tru	ctive Pu	lmonary	Dise	ase		Onset and Death
	/Medical Examiner									
H		er	Sequentially list conditions, if any leading to immediate	12 U	LMON16	2				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence or form that the consequence of the	00	ardia	e IN	Larc	tion		
oʻ	te be executed ysician and le burial-transit		540 (0) 45 2 05 150 440 165	of):	. 0	1	0			
8760,	m	lical	L. Renal	10	ailur	e				
Box 6	Physicion: The law requires that the death certifica this certificate has been signed by the attending pl rai director, page 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d Da	te of deliver	nv
œ.	death	sicia	in the past 12 months? 1 Yes 2 No 1 Yes 2 No		Ectopic pregnancy Other (specify)					Day Year
P.O.	at the	Phys	9 Li Unknown							
Š,	res th signed	by	Part II. Other significent conditions contributing to death but not resulting in Diaberis Type II. Arrhythmia Hypertension	in the und	derlying cause giver	n in Part I.				e cause of death?
Ö	requi	eted	1. 1 1/2 1/2				1421	'es 2□No	3 Proba	ably 4 □Unknown
Rec	has by	Completed	AFFRYTAMIA				24a. Was a autop perfor	sy	Were autop prior to com death?	sy findings available pletion of cause of
<u>a</u>	in: Th		Hypettension 25. Was case deferred to medical			00 Disease (D. 11	1 Yes	2 W No	1 ☐ Yes 2	200 No
₹	ysicle s cert direct	To Be	examiner? 1 Yes 2 VNo Hospital: 1 VInpatient 2 ER/Ou	utpatient		26. Place of Death 4 ☐ Nursing Hor			er /Speciful	
5	ng Phi ter thi		27. Manner of Death 28a. Date of Injury 28b. 1	Time of Injury	28c. Injury a	at :		ow injury occur		<u> </u>
Sio	tendir eath. or: Af	catic	2 Accident investigation			es 2□No				
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stree	et, factory, office	1	28f. Location (S City or Tow	itreet and Numb n, State)	er or Rural	Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and and maner stated.	e, death o	occurred at the time estigation, in my opin	o, date and place, a nion, death occurre	and due to the o	ause(s) and ma	nner as sta	ited. the cause(s)
	o the	Me	one) and manner stated. 29b. Signature and title of certifier		29c. License	number		29d. Date signe	d (Month, D	lay, Year)
•	->-0		Marres, MD		RE	-S-00	00 1	lovem	Ber	10 2004
	1		30. Name and address of person who completed cause of death (Item 23a) ((Type, P		ena 6	itel	SON	2	1239
						Raven	Bevel	, Balti	more	e, MO
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature							
DH	MH 17 Rev 1/2		31. Date (iled (Month, Day, Year) 32. Registrar's Signature	Ann	ر مجمع					
				GINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes O. O. I.

			For State Registrar		State of Ma	aryland /	Depa Cer	irtment of H <i>tificate of L</i>	ealth ar D <i>eath</i>	nd Menta	l Hygie	ne 0	04	351	830
Г	*	,	1. Decedent's Name (Firs	st, Middle, Last)					-		e of Death			3. Time o	
	Physicia /Medic		James	H	[.		Ri	ley		Nov	nth vember	Day 2	Year 004	4:1.	5 PM
	Examin		4a. Facility Name (If not in	nstitution, give s	treet and number)			4b. City, Town, or	Location of [4c. County			
et .			Crofton Co			er		Croft				Anne	Arund	e1	
	Funeral		5. Social Security Number	r 6. Sex	7. Age	e (In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date Min. (Mor	of Birth oth, Day, Ye 29, 1	ear)	9. Birthpla Count	ace (State	or Foreign
	Director		551-12-318 Usual Residence of Dece			98	115.			Mar.	29,1	.906	Penn	sylva	ınia
	/land			County		10c. City, To	own or Loc	cation					10	d. Inside C	City Limits
	Man 9-f sh	tor	MD H	loward		E11:	icott	City					£	1 X Yes	s 2 □ No
	th the	Director	10e. Street and Number					10f. Zip Code			10g.	Citizen of	What Count	ry?	
	death with the Maryland ms 23s or 28e-f show rmust be notified at		3439 Plum	Tree Dr	., Apt. I)		21042			į.	USA			
	tems	Funeral	11. Marital Status		Was Decedent I Amed Forces?	Ever in U.S.	13. W	vas Decedent of Hi Yes, specify Cuba	spanic Origin n, Mexican, F	n? (Specify Yes	s or No-		e - America		
30	uid be filled within 72 hours after death with the Marylan fental Hygiene. rked other then "natural", or tiems 23s or 28e-f show tic event, It a Madical Examination to collined at	by Fu	1 Never Married 2 3 Widowed 4 X D		1 XYes 2 □ N If Yes, Give		1	☐ Yes 21X No	Specify:		,	Specif		hite	
5-0036	hour			Decedent's Educ	Year or Dates:			ent's Usual Occupa	ation		169				
212	nin 72 n "na n dis	Completed	(Specify on	ly highest grade	completed)		(Give k	kind of work done of NOT use retired	lu <i>rina</i> most oi	f working	100	o. Killa of B	u <i>s</i> iness/Indi	JSITY	
7	d with giene or the	mo	Elementary/Secondary	(0-12)	College (1-4or 5 4		Chief	Petty 0:	fficer		U.	S. Na	vy		
9	e file al Hy i othe vent	Be	17. Father's Name (First,						18. Mother's	Name (First, I	Middle, Mai	den Suman	10)		
yiand	should to and Ment marked umatic e	2	James Rile	У					Jane	t David	lson				
Mar	2 short and last m		19a. Informant's Name/R					g Address (Street a							
	ss 1 and 2 should to the stand Ment item 27 is marked rother treumatic for the treum		Gerald Ril		.)			Plum Tree	e Dr.,	Apt. D					21042
ב ס	Pages nent of H ent: If ite ury or of		1 □ Burial 2 X Cre	mation 3 🗆 Re	emoval from State	ceme	tery, crem	atory or other place					City or Tov		
Barrimore,	_ P P B		4 □ Donation 5 □ 021. Signature of Funeral		Δ	Metro		matory		/11/200			re, M	D	
g	Depar Depar Impor eny ir		>73m	J. Y				Name and Addres Hardesty 12 Ridge	Lv Avei	nue. An	napol	is. M	D 214(01	
			23a. Part1. Enter the dis	ease, or comple ire. List only on	cations that caused e cause on each lin	the death. D	o not ente	r the mode of dying	, such as ca	rdiac or respira	tory arrest,			Approxima Interval Be	ite tween
	Physician		Immediate Cause (Final disease or condition	a a			1/2	umon,	,					Onset and	Death
	/Medical Examiner		resulting in death)		Due to (or as	a consequenc	ce of):							1000	
		<u>_</u>	Sequentially list condition	ns, b	Due to (or as a	2 0000 10110	O								
1	nsit	mlne	cause. Enter Underlying Cause (Disease or injury	4	ero estra as	ar ocurrencyangiras	ic sty								
· ,	execun and ial-tra	Examiner	that initiated events resulting in death) Last	C.	Due to (or as	a consequenc	ce of):								
09/89	that the death certificate be executed ed by the attending physician and detached for use as the bunal-transit	ledical		d											
	rtifica ng ph as th	Medi	IF FEMALE:									1			
X O D	requires that the death cer seen signed by the attendin hould be detached for use	hysiclan/M	23b. Was decedent pregi in the past 12 month	Harit	3c. If yes, outcome of 1 ☐ Live birth		ath 3 🗆 i	Ectopic pregnancy					te of deliver	,	
5	ne deg the a	/sic	1 Yes 2 No	13:	4□Pregnant at 9□Unknown	time of death	5 🗆	Other (specify)				Мо	ונוו ב	Day	Year
7.	hat the	۵.	Part II. Other significant	conditions con	tributing to death bu	it not resulting	n in the un	deriving cause give	n in Part I	230	Did tohace	co use cont	ribute to the	cause of	doath?
as,	w requires that been signed b should be deta	d by	•		•			, g g c			1 ☐ Yes	_	3 Probai		nknown
Hecords		leted				-				242	. Was an	24h 1	Mara auton		
Y Y	The law ite has b	ompl								-	autopsy performed	1?	Were autops prior to com death?	pletion of c	cause of
VItal	(0)	e C	25. Was case referred to	medical					26 Place of	Death (Check	Yes 2	Mo 1	☐ Yes 2	.LI No	
	Physicien: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ ¶o	Н	ospital: 1Inpatie	nt 2 ER/	Outpatient	3□ DOA Othe		ng Home 5		e 6 □Oth	er (Specify)		
n or	E e		27. Manner of Death Natural 5	Pending	28a. Date of Injur (Month, Day	y 28b	. Time of Injury	28c. Injury Work	at			njury occurr			
<u> </u>	Attending For death. ector: After by the funera	catto	2 ☐ Accident	investigation Could not be					′es 2□No						
UIVISION	of or Attendinates after death. Director: After to the furth of the f	Certification:	3 Suicide 6 4 Homicide	determined	28e. Place of Inju- building, etc	iry - At home, :. (Specify)	farm, stre	et, factory, office		28f. Loca City	ation (Stree) or Town, S	t and Numb tate)	er or Rural i	Route Nurr	nber,
_	pitel ours a erel (29a. Certifier	Rartifying Phys	ician: To the heart	of my knowled	lan dant	convered at the co	o dete		à- 11				
	To the Hospitel or Atti within 24 hours after de To the Funerel Directi completely filled in by t	edical	(Check only one)	Wedical Examin	ician: To the best of er: On the basis of and manner sta	examination	and/or inve	estigation, in my op	inion, death o	occurred at the	time, date	and place, a	and due to t	he cause(s	s)
	To ti To ti	Ž	29b. Signature and title o	f partified				29c. License	number		29d.	Date signed	(Month, D	ay, Year)	
•			100	1 De	WY)			h 7	17931		1	11/10	1700	14	
	10		30. Name and address of	/		eath (Item 23a	D (Type, P	Sourh	Dine	Cho	Le,	Mi	2161	9	
	Sta Registr		31. Date filed NOV 1			ır's Signature	G	Print)							
						/		Carely							

			State of Manyla		artment of Health	•	-	
			1 - For State Registrar		rtificate of Death		ZUIIL	35831
			Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death
	Physici /Medic		DORIS M. RUFFO			Month NOV	Day Yea q 2004	2:30A M
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	of Death	4c. County of De	
			1830 Hanford Rd. 5. Social Security Number 6. Sex 7. Age (In ye	en land hinth day)	Baltimore Co		Baltim	
	Funeral Director		214149317 1 M 2 T F 82	rs. last birthday) Yrs.	Months Days Hours		Y. Year Ogg	irthplace (State or Foreign Country)
	D		Usual Residence of Decedent				, , [4]	aryland
	arylar show	2		City, Town or Lo				10d. Inside City Limits
	the M	ecto	Maryland Baltimore	Balti	nore County 10f. Zip Code		10-000	1 Yes 2X No
	3e or	Funeral Director	1830 Hanford Rd.		21237		10g. Citizen of What	Country?
	death	nera	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Ori f Yes, specify Cuban, Mexicar	igin? (Specify Yes or No)- 14. Race - Ar	nerican Indian,
98	or its	/ Fu	1 ☐ Never Married		rres, specify Cuban, Mexicar 1□Yes 2√√No <i>Specify:</i>	n, Puerto Rican, etc.)		
00	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "netural", or itams 23e or 28e-f show avent, the Medical Examinar must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				Specify: W	
15	n "ne	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Busines Baltimore	
212	d within giene. ar than "	Com	Elementary/Secondary (0-12) College (1-4or 5+) N/A	Sec	cretary		Board of Edu	
pu	be filed Ital Hygie d other avant,	Be	17. Father's Name (First, Middle, Last)		18. Mothe	er's Name (First, Middle	, Maiden Sumame)	
Maryland 21215-0036	should be and Mental is marked of aumatic ava	L _O	Arthur L. Webb			a V. Danie		
Mai	TENE		19a. Informant's Name/Relationship (Type, Print) Kenneth T. Ruffo (Son)		ng Address (Street and Numbershot Court P			Zip Code)
ē,	Hear Hear Hear Her		20a Method of Disposition 20b	Place of Dispo	sition (Name of	Date	20c. Location - City	or Town, State
E O	90 = 5		X∑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	ardens (of Faith Cem.	11~12~04	Baltimore,	Md.
Baltimore,	permit. Pag Depertment Important: i any injury o		21. Signature of Funaral Service Licensee	11 L	Name and Address of Facility assahn Funera 401 Brlair Rd	L Home	Md 2122	2
	45.1		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.					Approximate
	Physician		Immediate Cause (Final disease or condition					Interval Between Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a const	equence of):	C			70.70
a	ZAGIIIIICI	7	Sequentially list conditions, if any, leading to immediate		rokes			H
K	uted Insit	Examiner	cause Enter Underlying		IS OF ADRIN	+ CAROTI	05	f1
o,	e be executed ysician and e burial-transit		Due to (or as a conse	equence of):				
8760,		licai	d. DIABETE	S MELL	itus, type -	IL .		11
89 X	The law requires that the death certifica Ite has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was deceded program: 23c. If yes, outcome of preg	nancy	N/I AN			
Вох	death atten	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ital death 3	Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year
0	at the de by the tached	hysi	9 Unknown		,,			
S, D	res that igned I be det	by P	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ord	w require been si should b					101	res 2 XNo 3 ☐ F	Probably 4 Unknown
Vital Records,	e ław has b je 2 sl	Completed				24a. Was	prior to	utopsy findings available completion of cause of
a			OF Was associated to medical			1 ☐ Yes		s 2 No
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♠ No Hospital: 1 ☐ Inpatient 2 €	☐ ER/Outpatien	044	of Death (Check only or rsing Home 5 Resid		
οl		H-	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?		now injury occurred	эспу)
Siol	ttandir death. ctor: Af y the fu	catlo	2 Accident investigation	,,	M 1 Yes 2 1	No		
Division	il or Attanding Pafter death. Diractor: After id in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office	28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
	e Hospital or Attanding 24 hours after death. a Funeral Diractor: After etely filled in by the fune		29a. Certifier 12 Certifying Physician: To the best of my kr	nowledge, death	occurred at the time, date and	d place, and due to the	rause(s) and manner s	e stated
	To the Hospital or within 24 hours afte To tha Funeral Dis completely filled in	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	nation and/or inv	estigation, in my opinion, deat	h occurred at the time,	date and place, and du	e to the cause(s)
	To the I within 2. To tha I complet	Σ	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	th, Day, Year)
Ţ			nigo oceopino		0004762	5	11/9/04	
	\mathbb{O}		30. Name and address of person who completed cause of death (Ite RICHARD O'MALIEN, MD 76)	m 23a) (Type, I	en once, s	it= 211	TOWGON	ma 21704
	∞ sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	· · · · · · · · · · · · ·	いしつり、	10-3014/	- 17 61 60
Ŀ	Registr	ar	NOV 1 2 2004 Sancta	& pp	rocks			

B.K.S

VERNON	RAPHAE	L	JR • For 1 = State Registrar		State of	Maryla	nd / Depa	rtment of I	Health and N	Mental Hy	giene	004	358	32
			Hegistrar Decedent's Name	(First, Middle, I	Last)		061	incate of	Dealii	2. Date of De	Reg. No.		3. Time of	
	Physici		Ve	rnon	Raph	امه	Jr.			Month NOV •	Day	Year 2004	0735	A M
	/Medic Examin		4a. Facility Name (If				01.	4b. City, Town,	or Location of Death			County of Death	10733	_A
	ZX		SINAI	HOSPITA	\mathbf{L}			BALTIM	ORE CITY			N/A		
	Funeral		5. Social Security Nu	mber 6			. last birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	rth		lace (State o	r Foreign
	Director		219-17-0		1 X M 2□F	22	Yrs.			1-28-	-82		imore	∋,Md.
	and w		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	ation				1	0d. Inside Cit	tv Limits
	the Marylan 28a-f show notified at	lor	Md.	N/A			Balti	moro					t ⊡Yes	-
	r 28a	rec	10e. Street and Num				Darti	10f. Zip Code			10g. Citiz	en of What Cour		
	h with	al D	5908 C	rossCo	untry B	lvd.		2121	5		USA	Δ		
	within 72 hours after death with the Maryland ene. than "neturel", or Iteme 23e or 28e-f show I.a McJical Examilian I. and be motified at	Funeral Director	11. Marital Status		12. Was Dece Armed For	dent Ever in l	J.S. 13. V		Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No		4. Race - Americ		
98	or Ite	y Fu	1 Never Marrie			2 VNo		☐ Yes 2X No		o racan, etc.)		Black, White, Specify: Bla		
Ö	hours ural',	d by	3 Widowed		Year or Da	ites:								
7	n 72 "nat	Completed	(Specia		Education grade completed)		16a. Deced	ent's Usual Occup ind of work done O NOT use retire	pation during most of worl ed)	king	16b. Kin	nd of Business/Inc	dustry	
12	withi ene. than	duc	Elementary/Secon	dary (0-12)	College (1-	-4or 5+)		udent	,,,,		Sch	nool		
b	Hygothar othar	Be C	17. Father's Name (F	First, Middle, La	st)			uuciit	18. Mother's Nam	ne (First, Middle				
<u>'a</u> n	should be filed nd Mental Hygi i markad othar umatic event, I	To B	Vernon	Raph	ael Sr.				Karen	Curr	·v F	Raphael		
Maryland 21215-0036	s ma		19a. Informant's Nar				19b. Mailin	Address (Street	and Number or Ru					
≥	and 2 saith a n 27 is		Karen	Rapha	el Moth		5908	Cross	Country	Blvd.E	Balti	imore.M	d.212	215
ore	of He		20a. Method of Dispo		☐Removal from S	4	Place of Dispos	ition (Name of atory or other pla		Date	20c. Loc	ation - City or To	wn, State	
Ë	Pag ment ant: I		`4 □Donation				ing Me	m.Park	11-3	11-04	Ba1	timore	Md.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: If item 27 Is marked other than 'natural', or Itema 23s or 28s-f show any foliary or other traumatic event, if a Medical Examinating the molified at once.		21. Signature of Fun	eral Service Lic			22. E	Name and Addre						
			23a. Part1. Enter the	on ask	20	used the dea	th. Do not ente	the mode of dvi	DAW Plac	e,Balt	<u>Imor</u>	e;Md.	21217 Approximate	
	26,		shock, or heart Immediate Cause (F	Tallule. List Oil	ly one cause on ea	ich line.		1 (1-0	or rospiratory a	rrest,		Interval Betw Onset and D	veen
	Ph ysicia n /Medical		disease or condition resulting in death)		aQun	or as a conse	COOCI	ia ot	nead					
	Examiner				1 3		44000 0.7.							
	n =	ner	Sequentially list con- if any, leading to immorause. Enter Under	ditions, nediate vina	b. Due to (d	or as a conse	quence of):							
	ficate be executed physician and is the burial-transit	Examiner	cause. Enter Under Cause (Disease or in that initiated events resulting in death) La	íjury	c									
50,	oe exclan g	Ď.	resulting in death) La	331	Due to (d	or as a conse	quence ot):					1.5		
68760,	physic the t	edical		•	d									
	eath certifi attending for use as	//We	IF FEMALE:		23c. If yes, outo	ome of pregn	ancy				25	3d. Date of delive		
Вох	leath atter	clar	in the past 12 m	nonths?	1 ☐ Live bi	rth 2 ☐ Feta ant at time of c	al death 3□	ctopic pregnancy Other (specify)	у		23		,	'ear
P.0.	that the d ed by the detached	Physiclan/M	9 Unknown	NO	9□ Unkno	wπ								
<u>ب</u>	es tha igned b	by P	Part II. Other signific	ant conditions	contributing to de	ath but not re	sulting in the un	derlying cause giv	ven in Part I.	23e. Did t	obacco us	e contribute to th	e cause of de	eath?
ğ	w require been sig should b									1 🗆 `	Yes 2	ľNo 3 ☐ Proba	ably 4 ⊟U	nknown
ဝွ	law requas been 2 should	plet								24a. Was		24b. Were autop	sy findings a	vailable
Division of Vital Records,	9 4 9	Completed									rmed?	prior to con death? 1 XI Yes	npletion of ca 2□No	use of
ita	iclan: Th certificate rector, pag	Be (25. Was case referre	ed to medical					26. Place of Deat					
of V	Physic this or	^o L	XXYes 2□N	lo			ER/Outpatient		4 Nursing no	ome 5 Resid	dence 6	☐Other (Specify)	
Ę.	ding P h. After t funera	lon:	 Manner of Death Natural 	5 Pending	2 1 4 .	f Injury n, Day Year)	28b. Time of Injury	28c. Injur Wor	rk?	28d. Describe			1	
isio	r Attand er death ractor: / by the f	icat	2 ☐ Accident 3 ☐ Şuicide	investigat	be OD- Di	-04	07:10		Yes 2 No		bjec			
)iV	after Dirac	Certification:	4 Homicide	determine	buildin	g, etc. (Speci	nome, farm, stre	at, ractory, office		5 Por To	yn, State)	Number or Rural	Houte Numb	ind
	Hospital		29a. Certifier	Certifying I	Physician: To the	best of my kno	owledge, death	occurred at the tir	me, date and place,	and due to the	AM &	nd manner as ets	atod	
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only one)	Medical Ex	aminer: On the ba and mann	sis of examina	ation and/or inve	stigation, in my o	ppinion, death occur	red at the time,	date and p	place, and due to	the cause(s)	
	withir To the Comp	M	29b. Signature and t	tle of certifier	0/	20		29c. Licens			29d. Date	signed (Month, L		
4	,		Het		-10	1) h	cy .	0,	.C.M.E		NOV	. 5 . 4	2004	
,	ϑ		30. Name and addre	ss of person wh	o completed cause	8 6 1	m 23a) (Type, F							
A			31. Date filed (Mont)	Day Your	chica-k	JAKU-	11 Penr		, Baltimo:	re, Mar	yland	21201		
	Sta Registr		Ji. Date illed (MONI	NOV I'2	2004	gistrar's Sign		Spor	12/					
		100			7									

State of Maryland / Department of Health and Mental Hygien 2004 35833 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** Beverly E. Ransome Nov.06,2004 2:45Pm! /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randalistown 8905 Harkate Way 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) 1 □ M 2√□ F Yrs. Director 65 Maryland 216-36-1801 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Myclical Examinar must be notified at 1 ☐ Yes Ž☐ No Randallstown Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8905 Harkate Way 21133 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 🛣 No Specify: Black 3 ☐ Widowed 4 🗓 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Barton Cotton Hygiene. Blinder Worker 12 permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ross H. Sye Delores B. Sye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13720 Sumpter Rd Carleton, Michigan 48117 Osmund McGowen Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Baltimore, Md * 4 ☐ Donation 5 ☐ Other (Specify) 11/11/04 Arbutus Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 Leck Ester 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the attending IF FEMALE: USB 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death Year Day 5 Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> 2 12010 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 **N**o 1 Tes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl o e) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 tural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COULEN 6569 MP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State	i icas		Marylan	d / Depa		t of H	ealth a	and M	lental Hy	giene 0	04	35834
	Physici	an	Registrar 1. Decedent's Nam Mildred		Last)			inout	0 01 2	Journ		2. Date of Dea		Year	3. Time of Death
	/Medio Examin	al	4a. Facility Name (/	If not institution, g						Location		11 00	4c. Cou	inty of Death	
			Mariner 5. Social Security N			1.1e 7. Age (<i>In yr</i> s.	last hirthday)			Ville If Under		8. Date of Birt		timor	
	Funeral Director		215-03-9 Usual Residence of	732	1□M 2₽	86	Yrs.	Months	Days	Hours	Min.	(Month, Day 04–23–1	r, Year)		place (State or Foreign intry) yland
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merial Hygiene, item 27 is marked other than "neturel; or flems 23s or 28e-f show other treumetic event, if a Medical Eventre must be notified at	2	10a. State	10b. County	-	10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ecte	Md 10e, Street and Nu	Balti	more	Cat	onsvi	10f. Zip	Code				10g. Citizen	of What Cou	
	3a or	ä	1502 Fre		beo				1228				U.S.		,
	death	Funeral Director	11. Marital Status	del lek 1		dent Ever in U	.S. 13.			ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Amer	
9	or Ite			ied 2 Married		2-11 No	Ì	1 Yes		Specify:	1, Fuerto	nican, etc./		3lack, White <i>cify:</i> Whi	
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븚	는 돈 뿐 글 .		21. Signature of Fu	5 Other (Spe uneral Service Li		Lor	raine		d Addres						Maryland Directors
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	Priyaician / Medical Examiner	Examiner	shock, or heal Immediate Cause disease or condition resulting in death) Sequentially list confiant, leading to incause. Enter Unde Cause (Disease or that initiated event, resulting in death)	onditions, and all of a light of the conditions, and all of a light of the conditions of the condition	b. Due to (or as a consequence or a consequence or a consequen	juence of):		um						Interval Batween Onset and Death
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case references		Hospital:				Oth			(Check only o			
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Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 4 Homicide	6 Could no determin	t be 28e. Place	of Injury - At h	ome, farm, st fy)	reet, factory	y, office		2	28f. Location (S City or Tow		mber or Rui	al Route Number,
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)		30. Name and add	ress of person w	m	e of death (Iter		Print)	nve	218	108	Bath	nore	, MD)
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	Registi	rar	NOV	1 2 200	Bers	ver	D A	your	2						

DHMH 17 Rev 1/2001

Amend item #1 per MD, G838 12/8/04 TT
State of Maryland / Department of Health and Mental Hygiene On the Company of the Compan 1 - For State Registrar 35835 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Robert 2. Date of Death Rinehart Month Year **Physician** 12:30 P^M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hammonds Brooklyn Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplece (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 70 Yrs Jan. 215-30-0220 25, 1934 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County or 28a-f show the Medical Examinar must be notified at 1 Yes 2 XNo Director MD Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 405 Hillcrest Avenue 21225 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married natural, or 1 ☐ Yes 2 💢 No Specify: Specify: White δ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) 11 Welder Ship Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Rinehart Viola Baumas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Hillcrest Avenue, Baltimore, MD 21225 Roberta L. Squires Daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Holly Hills Memorial Gardens 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Essex, MD 21. Signature of Funeral 22. Name and Address of Facilimbrose Funeral Home, Inc. arl 2719 Hammonds Ferry Rd., Lansdowne, MD 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Netastatic Physician /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): the attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown ģ sate has been signed page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 nknown 126876 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ∰No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) uneral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OAKWOOD ROAD Glen Burnie, MD

State Registrar

DHMH 17 Rev 1/2001

with the Maryland

death

within 72 hours after

certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0036

NOV 1 2 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

7845

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Month Year **Physician** HENRY ROSENZWEIG NOV 0 1:091 M 2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BRIGHTWOOD NURSING HOME LUTHERVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth Month, Pay, Year) APR. 14, 1914 Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 90 Yrs. Director 217-05-6597 MASS. Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene. Important: If them 27 is marked other than "nature" any injury or other traumatic excessions. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director MD BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6806 OLD PIMLICO ROAD 21209 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 M Yes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. WHITE ģ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MERCHANT LADIES CLOTHING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 ROSENZWEIG ABRAHAM IDA ISRAEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 6806 OLD PIMLICO ROAD - BALTIMORE, MD 21209 SHIRLEY ROSENZWEIG / SIS-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MOGAN ABRAHAM CEMETERY 11/10/04 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licens SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) DEMENTIA Monuns Examiner Due to (or as a consequence of) MONTHS SUS EASE CORONARY ARTERY attending physician and for use es the bunal-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of deeth? 3 Probably A Unknown 1 Yes 2 No ģ 24b. Were autopsy findings available prior to completion of cause of death? certificete hes been si lirector, page 2 should Completed 24a. Was an autopsy TUYOS 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No After thi 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No efter deeth.

Director: A
d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide ō within 24 hours oft.

To the Funeral Dill

completely filled in 29a. Certifier 1 Quitifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) Sgupte MD NOV 9Th 2004 00053150 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) SHAKUNMALA GUPTA MD 80 BOX 6303 ELLICOTT 474 4042 31. Dete filed (Month, Day, Year) NOV 1 2 2004 32 Registrar's Signeture State Registrar

			For State	State of Man	land / Dep	artment of F rtificate of	Health and N			04 3583
		48	Registrar 1. Decedent's Name (First, Middle, Last)			TuilCale Oi	Dealii	2. Date of Death	· g. 110.	3. Time of Death
	Physici		Helen Viola	Reyroth				November		ear 705 M
8	/Medic Examin		4a. Facility Name (If not institution, give		1	4b. City, Town, o	or Location of Death		4c. County of	777
			Lorien @ 1	Liversia			sclam	P	Har	ford
	Funeral		5. Social Security Number 6. Sex	M 287F	n yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	N8. Date of Birth (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
	Director		214-62-0690 Usual Residence of Decedent		39 ""			Dec. 5,	1914 M	Maryland
	yland now		10a. State 10b. County	10	C. City, Town or L	ocation		-		10d. Inside City Limits
	Mar a-1sh	ctor	Maryland Harford		Bel Air	•				1 ☐ Yes 2 🛣 No
	ith the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Country?
	ath w		303 Lakeside Dr			210	015		USA	.
	er de Items	Funerai		12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		American Indian, White, etc.
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ē,	s 1 and 2 f Health item 27		Kenneth E. Rexro-	·	20b. Place of Dispo	osition (Name of matory or other place	oury Rd.,			14 ty or Town, State
Baltimore,	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			. !	_11_04	Bol Nir	Maryland
alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	99	2	2 Name and Addre	occ of English			**
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Вох	leath certifii attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy	у		23d. Date o Month	f delivery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tim 9☐ Unknown	e or death 5	Other (specify) _				,
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00	aw require as been si 2 should b	plet	Hundlaw	w Aism				24a. Was an		re autopsy findings available
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	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	alc	29a. Certifier 110 Certifying Phys	ician: To the best of m	y knowledge, deat	h occurred at the tir	ne, date and place,	and due to the cau	use(s) and manne	er as stated.
	he Ho in 24 he Fu pletel	edical	(Check only 2 Medical Examir one)	ner: On the basis of exa and manner stated	amination and/or in	vestigation, in my o	pinion, death occur	red at the time, dat	e and place, and	due to the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier	111.		29c. Licens				fonth, Day, Year)
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	1		30. Name and address of person who co				10/ 1	ol Air	1.0.1	1014
	∘ ° Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's		Mad 1	14 /4	W HIV	puria	(0) (
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			1 - For State Registrar	State of M	aryland /	Depa <i>Cei</i>	artment of H	ealth an D <i>eath</i>	d Mental Hyç	giene () Reg. No.	04	358	338
	Division		1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ath Day	Year	3. Time of	Death
	Physici /Medic		James A.	Robinsor	1				NOV.		2004	4:00	Ам
	Examin		4a. Facility Name (If not institution	•			4b. City, Town, or		eath	4c. Coun	ty of Oeath		
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	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birtl Min. (Month, Day	h v. Year)	9. Birthp	place (State ontry)	or Foreign
Н	Director		180-26-2780 Usual Residence of Decedent	Λ	71				MAY 29,	1933	Penr	ısylva	nia
	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation		·		1	0d. Inside C	ity Limits
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	r 288	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cour	ntry?	
	th wit		4318 Leola Av	enue			2122	7		USA			
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces		13. \		spanic Origin?	? (Specify Yes or No-	14. Ra	ace - Americack, White,		
9	or fte		1 ☐ Never Married 2 🔀 Mar	ried 1 Yes 2	No		1 ☐ Yes 2 ᡚ No	Specify:	dorto riloani, oto.,				
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	be filed within 72 hours after death with the Marylan ital Hygiene. Ind other than "natural", or ftems 23a or 28a-f show event. The Modical Extra first mast be notified at		17. Father's Name (First, Middle,	Last)		<i>E</i>	Auditor	18. Mother's	Name (First, Middle,	Fdison Maiden Suma		ners Si	noes
an	Mental Mental arked c	To Be	James Robinso	n				Robert	a Wood				
Maryland	2 should be filed and Mental Hygi is marked other eumatic event.	-	19a. Informant's Name/Relations		1	9b. Mailin	ig Address (Street a		r Rural Route Numbe	r, City or Tow	n, State, Zip	Code)	
	rt 2		Jeanette M. Ro	binson - wif	e	4318	Leola Av	enue, E	Baltimore,	MD 2	1227		
ore	of Head	1 8	20a. Method of Disposition 1 Burial 2 □ Cremation	2 Domestal from State	ceme	etery, cren	sition (Name of natory or other plac	θ)	Date	20c. Location	,		
Ē	Page nent ant: ff		' 4 □ Donation 5 □ Other (5		Meado	wride	ge Mem. Pa	ark¦ ll	L/10/2004	Elkric	dge, M	1 D	
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service	tukman		Ga:	Name and Addres	is of Facility Ifman Fr	uneral Hom	ne @ Mea	dowri		Inc.
			23a. Part1. Enter the disease, o	complications that cause	d the death. D	72. So not ent	50 Washin er the mode of dyin	gton B	lvd., Elkr diac or respiratory ari	ridge,	MD 2	L075 Approximat	е
			Immediate Cause (Final	only one cause on each i	ne.				ROVASCUI		1201	Onset and	ween Death
	/Medical		disease or condition resulting in death)	a	a consequent		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,). — DI		J 17 (-30	136	
п	Examiner		Sequentially list conditions,	b									_
	sit sit	iner	if any, leading to liminediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	à consequen	ce oi).							
	xecut and II-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequent	ce of):	· · · · · · · · · · · · · · · · · · ·						
8760,	death certificate be executed e attending physician and od for use as the burial-transit				, , , ,	,-							
687	flicate g phys	edical		0									
Вох	leath certific attending p I for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			10-4			23d. D	ate of delive	ery	ļ
	death	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth			Ectopic pregnancy Other (specify)			M	lonth	Day ^	Year
P.0	that the do	Physician/Me	9 🗆 Unknown	9□ Unknown									
	Se un ec	by	Part II. Other significant conditi	ons contributing to death t	out not resultin	g in the ur	nderlying cause give	en in Part I.		bacco use cor es 2 □ No	ntribute to th		leath?
Records,	w requires been sign should be	Completed											
3ec	2 2	ld m							24a. Was a autop:	sy	. Were auto prior to cor death?	psy findings npletion of c	available ause of
al	Th ate								1 ☐ Yes	2 DNO	1 🗆 Yes	2 40	
Vital		o Be	25. Was case referred to medical examiner?	Hospital:			Othe	n /	Death (Check only or				
of		-	1 Yes 2 Mo	28a. Date of Inju	ıry 281	Outpatien b. Time of	1 3LJ DOA	Nursin	g Home 5 Residence 128d. Describe h			/)	
on	Attending Phr r death. sctor: After thi by the funeral	tlor	Natural 5 Pendii	ng (Month, Da	ny Year)	Injury	Work	(? Yes 2 □ No					
Division	f or Attendi after death. Director: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place of In	jury · At home	, farm, str	eet, factory, office		28f. Location (S		ber or Rura	l Route Num	ber,
ā	tef or A rs after ef Dire ed in by	Certification:	4 Tronnelde	building, e	c. (Specify)				City or Tow	n, State)			1
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier Certifyii (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examination	dge, death and/or inv	occurred at the time vestigation, in my of	e, date and ploinion, death o	ace, and due to the cocurred at the time, d	ause(s) and m late and place	nanner as st , and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c. License	number	2	9d. Date sign	ed (Month,	Day, Year)	
	, ,		Jarney	, Valel	uan'		1	285	55-	11/8	104		
	HXI		30. Name and address of person			a) (Type,	Print) PAR 1/2	2 11=	10 His	AVE	BA	UD 1	ui)
	Sta		31. Date filed (Month, Day, Year	2. Regist	rar's Signature		K.	- 110	191113		212	08	
	Registr	वा		- State	100	1900							

			For State Registrar		State	of Ma	ryland / I	Depa <i>Cei</i>	artmen <i>tificat</i> e	t of H e <i>of L</i>	ealth : D <i>eath</i>	and M	lental Hy	gien Reg. N	L. C L -7	35839
	Physici		1. Decedent's Name	(First, Middle, Mary	Last)		St	avi	s				2. Date of De Month	ath 07	^{ay} 2004 ^{Yeer}	3. Time of Death 6:20a M
	/Medie Examir		4a. Facility Name (If Joseph						4b. City,	Town. or Balt	Location	of Death			c. County of Deat	h
	Funeral Director		5. Social Security Nu 216–20–8	584	.Sex 1 □ M 2 🔀 F	. "	(In yrs. last bii 78	rthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 4-1-2	th ly, Yea	r) 9. Birt Co	holace (State or Foreign untry) Md .
	show	'n	Usual Residence of 10a. State	Decedent 10b. County NA			10c. City, Tow		cation	re						10d. Inside City Limits ¶ Yes 2 □ No
	with the has or 28e-1	Funeral Director	10e. Street and Num		 Rd.	1			10f. Zip	Code 21229				10g. C	itizen of What Co	
920	perriat. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or Items 23a or 28e-1 show any injury or other traumetic avant, the Medical Exertire reast its restlined at Once.	by Funera	11. Marital Status 1 ☐ Never Marrie 3 😾 Widowed		1 □Ye	ecedent Ev Forces? s 2 No Give r Dates:		'	Vas Deced Yes, spec	ify Cuba	spanic Or n, Mexical Specify:	n, Puerto I	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, White	
21215-0036	d within 72 ho giene. ir then "natu ire Medical	Completed by	(Special Elementary/Second 7th grad		grade complete	d) e (1-4or 5+)	(Give life. I	lent's Usua kind of wo DO NOT us .ng Ho	rk done d se retired,	uring mos				Kind of Business/	
Maryland 2	uld be filed Mental Hyg arked othe aric avant,	To Be C	17. Father's Name (/ Samue]	First, Middle, La	st)	ı	Willis					er's Name nie	(First, Middle,	Maide	n Sumame) Louise	
	nd 2 sho tith and ! 27 is me r traume		19a. Informant's Nat		(Type, Print) Daug	hter	196						<i> Route Numbe</i> Saltimo 1		or Town, State, 2	
Baltimore,	Pages 1 aunent of Heanint: If itam		20a. Method of Dispo 1 Spurial 2 C	osition Cremation 3	☐Removal fro	_	20b. Place o cemete Garri	f Dispo	sition (Nan	ne of ther place)	D	6-04	20c. I	Location - City or Vings Mil	Town, State
Balti	permit. Departe Importe any inju	ĺ	21. Signature of Fun		censee				Name an			DATE:			nore, Md. North A	
	Physician /Medical Examiner	ner	23 Part1. Enter the disease, or complications, had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause leach line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):											Approximate Interval Between Onset and Death		
38760,	ficate be executed physician and is the burial-transit	dlcal Examiner	cause. Enter Under Cause (Disease or in that initiated events resulting in death) Li	njury ast	c. Due	to (or as a	consequence	of):								
.O. Box (The law requires that the death certificate has been signed by the attending by page 2 should be detached for use as I	Physiclan/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?		e birth 2 egnant at ti	f pregnancy Fetal death me of death		Ectopic pro						23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other signific	cant condition	contributing to	death but	not resulting i	n the ur	derlying ca	ause give	n in Part I				use contribute to	the cause of death
I Records,		Completed											24a. Was autop perfo 1 Yes		246. Were aur prior to o death? 1 🗆 Yes	topsy findings available completion of cause of
Division of Vital	ding Phy I. After this funeral d	Certification; To Be	25. Was case referrence examinar? 27. Mann of Death 1 Hatural 2 Accident 3 Suicide 4 Homicide	5 Pending investigat	28a. Da (M	☐ Inpatient te of Injury onth, Day ace of Injur ilding, etc.	Year) 28b.	Time of Injury	M	8c. Injury Work 1 Y	r: 4 □ Nu	rsing Hon 2 No	Check only one 5 Residence Red. Describe has been considered as the Red Red Red Red Red Red Red Red Red Re	dence low inju	nd Number or Ru	ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funaral Diractor: completely filled in by the	edical Ce	29a. Certifier (Check only one)	1 Certifying	aminer: On the	the best of basis of e	xamination an	e, death	occurred a	at the time in my op	e, date an inion, dea	d place, a	and due to the o	cause(:	s) and manner as ad place, and due	stated. to the cause(s)
)	To the within 2 To the comple	Mec	29b. Signature and t	itle of certifier	Pallon	e M			290	License	number	2		29d. Da	ate signed (Month	n, Davf Year)
	10		John,	ss of polson	no completed ca	ause of dea	ath (Item 23a)	Typ.	Print	11/01	1	Rd	Buh	En.	11/2	2/2/8
7	Sta Registi		NOV 1		Sener.	. Registrar	s Signature	Spi	uks)		

			For State Registrar	State of Maryla		artment of H			giene Reg. No.200	4 35840
	Physici	an	Decedent's Name (First, Middle, Last	SMITH				2. Date of De Month	Day Y	aar 1130 4 M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o			4c. County of	
			2631 E. Preston 5. Social Security Number 6. S		. last birthday)	Balt If Under 1 Year	imore	8 Date of Bir	NA th	. Birthplace (State or Foreign
в	Funeral Director			□M 2 X JF 81	Yrs.	Months Days	Hours Min	. (Month, Da	2-23	Country) N.C.
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	e-f sh	ctor	Md.	AV	Balt	imore				1 X Yes 2 ☐ No
	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 2631 E. Preston	Street		10f. Zip Code 212	213		10g. Citizen of Wha	at Country?
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. do other then "neturel", or tiems 23a or 28e-1 show event, tra Medical Evantiner must be notified at	Ď	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Black,	American Indian, White, etc. Black
5-0	n 72 hc	leted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wa	rking	16b. Kind of Busin	ness/Industry
212	d within glene. r then	Completed	Elementary/Secondary (0-12) 10th grade	College (1-4or 5+)		memaker	,,		Own Home	
and,	should be filed withir of Mental Hygiene. marked other then imatic event, tre M	To Be C	17. Father's Name (First, Middle, Last) James	DeShaz	ZO		18. Mother's Na Kenny		, Maiden Sumame) DeSha	azo
Maryland	nd 2 :		19a. Informant's Name/Relationship (James Smith gi	Type, Print) Candson		ng Address (Street) 3 Mayfiel			er, City or Town, Sta	ate, <i>Zip Code)</i> 21213
Baltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State	cemetery, crea	osition (Name of matory or other placement)		Date -15-04	20c. Location - Cit	
Baltii	permit. Pages Department of Importent: If is any injury or o		21. Signature Funeral Service Licer			2. Name and Addres	ss of Facility H. East		ltimore, M E. North	
	Physician /Medical Examiner	niner	23a Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	100		DYSFUNCTIO	Approximate Interval Between Onset and Death H YEARS 25 YEARS			
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial transit	Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. DIABETE Due to (or as a conse d. 23c. If yes, outcome of pregr 1	quence of): nancy al death 3[□Ectopic pregnancy □ Other (specify)			23d. Date o Month	
<u>α</u>	uires that It signed by id be detac	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			ite to the cause of death?
il Records,		Completed						24a. Was autop perfo	rmed? dea	re autopsy findings available rocompletion of cause of th? Yes 2 \(\subseteq \) No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	757/0	Othe	00	ath (Check only o		
of	Jing After fune	tlon; To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury	4 Nursing F		dence 6 Other (Specify)
Division	Hospital or Attending 14 hours after death. Funerel Director: After tely filled in by the fune	Certification;	3 Suicide 6 Could not b 4 Homicide determined		nome, farm, str ify)	reet, factory, office		28f. Location (City or Tou	Street and Number own, State)	or Rural Route Number,
-	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C		ysicien: To the best of my kr niner: On the basis of examin and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 1		29c. License	e number		29d. Date signed (A	Nonth, Day, Year)
•	h		Jumpen H	male.			62032		NOVEMBE	R 8 2004
	}		30. Name and address of person who	completed cause of death (Ite	m 23a) (Туре, <i>Ца Ц</i>	Print) D Fasto	rn Av	Pril	Himore, W	B 21224
	Sta Registi		31. Date filed (Yeyth 10a2 Y 2004	62. Registrar's Sign	atury	print) Easte			110	

			1 State	nd / Department of Health and N Certificate of Death		2001.	35841
			Registrar 1. Decedent's Name (First, Middle, Last)	Communic of Beam	2. Date of Death	9. NG. UU4	3. Time of Death
	Physici /Medi		Emanuel	Simmons	Month	Day Year 2004	13:39 M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1.010
			The Johns Hopkins Hos	stal Baltinge (41	Ma	
-8	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr.	S.Vast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)		ace (State or Foreign
			Usual Residence of Decedent		NEVEMBER	8/736 N	
	inylan show	_	10a. State 10b. County 10c. C	City, Town or Location		10	d. Inside City Limits
	Be-f s	Director	M.D Ma	Bustimore			1 Yes 2 No
	ath with the Maryland s 23a or 28e-f show instite nutified at		10e. Street and Number	10f. Zip Code	100	g. Citizen of What Count	y?
	를 23 글	Funerai	11. Marital Status 12. Was Decedent Ever in	U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - America	n Indian.
9	after or ite	Fun	1 Never Married 2 Married 1 yes 20 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	
5-0036	rai',	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Blace	10
15-	na na	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing 16	6b. Kind of Business/Indu	istry
2121	filed within I Hygiene. other than rent, 'the M	omp	Elementary/Secondary (0-12) College (1-4or 5+)			Marile of de	1 & Bure
	e filed al Hyg other	O)	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	Maiyland duy	V BRICK.
/lar		To B	John CONNELEY	CAROLA	N Simon	162/5	
Maryland			19a. Informant's Name/Relationshi (Type, Print)	19b. Mailing Address (Street and Number or Rura	al Route Number, (City or Town, State, Zip C	
	s 1 and f Health item 27 other t		20a. Method of Disposition 20b.	Place of Disposition (Name of	Almong M	D 2/2/3 c. Location - City or Tow	
Ö	000		1 Surial 2 □ Cremation 3 □ Removal from State	centerery, crematory or other place)		_	
Baltimore,	permit. Pag Department Important: if any injury o		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			Bultimores 141	
B	permi Depa impo any ir		Potricia Bul	1129 N. CARULINE S.	_	MERG MO 212	13
	*		23a. Part1. Enter the disease, or complications that caused the deashock, or heart failure. List only one cause on each line.			t, /	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	cranial hemorrha	192	-	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conse	equence of):	J	-	1
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	ardits			4 months
	uted d ansit	Examiner	cause. Enter Underlying	ension		u	in Kunn
oʻ	be execuician and burial-tran	Еха	resulting in death) Last Due to (onas a conse	quence of):		- (TI WOOD T
8760,	cate be executed obysician and the burial-transit	dical	d. Deep in	enous thrombosis		4	years
9		/Mec	IF FEMALE: 23c. If yes, outcome of pregr	22504		J	
Вох	death certifii e attending p id for use as	clan	in the past 12 months?	tal death 3 □Ectopic pregnancy		23d. Date of delivery Month D	ay Year
0	that the death certific ed by the attending p detached for use as	hysi	1 🗆 Yes 2 🕽 Xo 4 🗀 Pregnant at time of 9 🗆 Unknown	ocali, ocali, opecny)			
ο, O	S C e	Completed by Physiclan/Me	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	cause of death?
ord	w require been sig should b	ted	tolysubstance abus	2	1 🗆 Yes	2 □ No 3 □ Probab	oly 4 Onknown
Records,	law asb 2sl	npie			24a. Was an autopsy	24b. Were autops	y findings available detion of cause of
E	- 5 m				performe	death?	□ No
Vital	Physician: this certific ral director,	Be c	25. Was case referred to medical examiner?	26. Place of Death			
ō		n; To	1 Yes 2 No Inpatient 2 Inpatie	28b. Time of 28c. Injury at 2	me 5 Residence 28d. Describe how	e 6 Other (Specify)	
ion	Attending Part death. actor: After by the funer.	atio	2 Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No			
Division	r Atte ter de iracto	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	nome, farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural F State)	Route Number,
	oital o urs af eral D	Cel	V				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the basis of examiner on the basis of examiner and manner stated.	nowledge, death occurred at the time, date and place, a lation and/or investigation, in my opinion, death occurre	and due to the caus ed at the time, date	se(s) and manner as state and place, and due to the	ed. ne cause(s)
	ro the vithin ro the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, Da	y, Year)
	. 7 - 0		Momen Lord m	OPADREX-OND)	evember .	9 2004
f	λ		30. Name and address of person who completed cause of death (Ite			D. Cinia.	1 2 2 2
			1 homas Lloyd 600		Homare	MD 21	287
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Sign NOV 1 2 2004	B Sports			

State of Maryland / Department of Health and Mental Hygiene 35842 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 1816 **Physician** Joan L. Shipley November 9 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗗 F 73 218-28-4525 Yrs Aug 12, 1931 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f show Maryland Harford Abingdon 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 United States 4026 Timothy Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) natural, or itame 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookeeper Restaurant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H is marked of permit. Peges 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any jury or other treumatic evonce. John Naff Emma Decker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4026 Timothy Drive, Abingdon, Maryland 21009 Brenda L. Shipley / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 11/12/2004 Baltimore, Maryland Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE Priysician DAY disease or condition resulting in death) COBSTRUCTIVE PULMONARY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine been signed by the ettending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY DISEASE 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 (27)No 24a. Was an this certificate has 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 No investigation after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ò within 24 hours a To the Funerel C 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number XC/Shalings D 31856 11/10/04 6025. ATWOOD RD # 106 BEL AIR ND 2/014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA MI) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 2 2004. Registrar

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Schmalzer Carroll Leroy 2, NOV. 2004 1018 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL 4b. City, Town, or Location of Death BALTIMORE CITY Examiner | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month Days Hours | Min. | Dec • 10, 1930 9. Birthplace (State or Foreign Country)
Balt. MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1.8 M 2□ F 212-28-5039 73 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itam 27 is marked other than "natural", or Items 23e or 28e-f shov other traumatic event, It a Nedical Examinant must be indifficed at MD Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1627 Eastern Ave. 21231 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 XYes 2 No IfYes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 📉 No 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Theatre Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. Projectionist permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if flam 27 is marked other than any injury or other traumatic evant, Itali once. 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Mae Brunner Joseph Carroll Schmalzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Schmalzer / Son 8609 Chesnut Oak Rd. Baltimore MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Baltimore MD. Bayview Crematory 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 24P. Charles L. Stevens Funeral Home Inc 1501 East Fort Ave Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ATMEROSLL Eno110 (ALDOVASCULM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner rsician and 9 burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical use as the IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be DIABRETES 2 10 3 Probably 4 □Unknown MERCITUS 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No 2 🗌 No 1 ☐ Yes 1 TYAS Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 2 1 🗌 Inpatient 2X ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending М investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

The law requires that the death certificate be exec P.O. Box 68760. Division of Vital Records, To the Hospital or Attending Physicien: death. within 24 hours after deat To the Funeral Director:

> State Registrar

G-21P 31. Date filed (Month, Day, Year)

ss of person who comp

32. Registrar's Signature

ted cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E

NOV.

2, 2004

30. Name and addr.

CPM 04-07230 Yahne Sangarey

∋ S	Sangarey	7	State of Ma	ryland / Department of Health and M fn G837 11-29-04 tas Certificate of Death	lental Hygie	ne or or or
				Certificate of Death		
	Physicia	an	1. Decedent's Name (First, Middle, Last)	C	2. Date of Death Month	Day Year 3.4 OT M
1	/Medic	al	YAHNEY MERIC-K 4a. Facility Name (If not institution, give street and number)	SANGAREV 4b. City, Town, or Location of Death	November	08, 2004 14:07 M
	Examin	er	1434 East Baltimore Avenue	Baltimore		N/A
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9 Birtholago (State or Foreign
	Director		110-74-6060 10M 2XF	58 Yrs. World's Days Flours	Month, Day, Ya	946 LIBERIA
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	/	10d. Inside City Limits
	Mary -f sho	tor	MARY/AND N/A	BALTIMORE	CITY	1.X Yes 2 □ No
	h the	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	23a c	ralD	1434 EAST BALTIMO	DRE ST: 21231		45A.
	er de a	Funeral	11. Marital Status 12. Was Decedent El Armed Forces?	If Yes, specify Cuban, Mexican, Puerto F	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	ours after death with the Marylan et', or items 23a or 28e-f show Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No. If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: BIACK
21215-0036	72 hours after death with the Maryland "naturel", or Items 23a or 28e-f show idical Examiner must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	na 16b	b. Kind of Business/Industry
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2	be filed within 72 ho ital Hygiene. id other then "natur event, he Med cal		17. Father's Name (First, Middle, Last)		(First, Middle, Maid	DELF-EMPLOYED
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ary	2 should and Men Is marke eumetic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	al Route Number, Ci	
	s 1 and 2 should f Health and Mer item 27 is marke other treumetic		DOM'S -	ON) 5500 HOLMES RUNPKU	UY UNITSOS	ALEXANDRIA, VA. 22304
Baltimore,	0 0		20a. Method of Disposition 1≯Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crematory or other place)		Location - City or Town, State
Ë			* 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	King Mem. Park 11-27	′-04 Woo	odlawn, MD
Bal	permit. Depertn Importe any inju		21. Signature of Purisian Service Licensee	TOSEPH H. B.	ROUN	TR. FUNERAL HOME BALTO, MD 21217
			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	the death. Do not enter the mode of dving, such as cardiac o		Approximate Interval Between
	Physician		Immediate Cause (Final	clerotic Cardiovascular Dise	2266	Onset and Death
7	/Medical		resulting in death)	consequence of):		
	Examiner	_	Sequentially list conditions, b. — Due to (or as a	consequence of):		
	rted	Examiner	Cause (Disease or injury	consequence on.		
Ć	execu in and ial-tra	Exa	that initiated events c. Pue to (or as a	consequence of):		
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9	entifica ling ph e as ti	w w	IF FEMALE:	4	ala Sala Annala	
Вох	leath certific attending p	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth 2	2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	at the de by the a	ysic	1 Yes 2 No 4 Pregnant at t 9 Unknown 9 Unknown	The or doubt		
۳,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions contributing to death but	t not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Records,	w require been sig should b	Completed by	Scieroderma		1 Tes	2 No 3 Probably 4 Unknown
ecc	e law r has be je 2 sh	nple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? **XYes 2 \sum No Hospital: 1 \sum Inpatien	26. Place of Death		6 Nother (Specify) SCENE
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Division	or Atter de Directo in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injured building, etc.		28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
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	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical		examination and/or investigation, in my opinion, death occurre		
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number 0.C.M.E.	29d.	Date signed (Month, Day, Year) DVember 09, 2004
			tan a tolk	l no	INC	JVEHIDEL US, ZUU4
			30. Name and address of person who completed cause of de	reth (Item 23a) (Type, Print) A/C111 Penn Street, Balt	imore Ma	arvland 21201
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registral	r's Signature	TROLE, I'K	
	Sta Registi		NOV 1 9 2004	to be done		

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	Physici		Dennis	Dennis B	ruce Spence Spencer	er Sr.	2. Date Mont	h [Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution	give street and number)		4b. City, Town, or Loc		mber	08, 2004 4c. County of Death	13:00 M
			702 Clover Ave 5. Social Security Number		e (In yrs. last birthday)	ESSEX	Under 24 Hrs. 8 Date	of Rinth	Baltin	
8	Funeral Director		220-66-2493	1 □ X M 2□ F	50 Yrs.		lours Min. (Mont	of Birth h, Day, Yea mber 2	8,1954 MD	place (State or Foreign htry)
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	ith the Marylan or 28a-1 show	Director	MD Balt	imore	Ess	ex				1 ☐ Yes 21 No
			10e. Street and Number 702 Clover Aven	ue .		10f. Zip Code 21221		10g.	Citizen of What Cour	ntry?
	after death w or items 23e	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Yes lexican, Puerto Rican, etc	or No-	14. Race - Americ Black, White,	can Indian, etc.
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Maryland	d be fill ental Hy ced oth	Be	17. Father's Name (First, Middle, Irvin Hicks Spe:				Mother's Name (First, M Elva Dorothy		ŕ	
ary	should be and Mental s marked o	To	19a. Informant's Name/Relations			ng Address (Street and I	Number or Rural Route N	lumber, Cit	y or Town, State, Zip	Code)
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mor	Pages ient of h int: If ite ry or of		1 ☐ Burial 2 ⚠ Cremation 1 ☐ Donation 5 ☐ Other (S)	3 □Removal from State	domotoni nin	natory or other place)	November 13, 2004		Location - City or To	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If tiem 27 is any injury or other trae		21. Signature of Funeral Service	icense	000 8	2. Name and Address of onnelly Fun	Facility Leral Home O	f Dun	dalk,P.A.	e i i i i
			23a. Part1. Enter the disease. or shock, or heart failure. List	complications that caused	the death. Do not ent	er the mode of dying, su	Point Road uch as cardiac or respirat	ory arrest,		21222 Approximate Interval Between
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68760,	icate be executed physician and s the burial-transit	edlcal		d						
	eath certific attending p	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of delive	erv
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		Ectopic pregnancy Other (specify)	· - · · · · · · · · · · · · · · · · · ·		Month	Day Year
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ion	nding I ith. :: After e funer	atlon	27. Manner of Death 12 Natural 5 Pendin 2 Accident investig	ation	y Year) 28b. Time of Injury Found	28c. Injury at Work? • M 1 ☐ Yes	Dece	ased v	jury occurred with exter ok methad	nsive cardia
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Ω	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1☐ Certifyin	Found: Re	esidence					
	the Ho	edical	(Check only one) Medical	xaminer: On the basis o and manner sta	f examination and/or in	vestigation, in my opinion	n, death occurred at the t	ime, date a	and place, and due to	the cause(s)
	To To Con	Σ	29b. Signature and title of certifier	nM		29c. License nur	.C.M.E.		pate signed (Month, in the signed of the signed (Month, in the signed of	
			30. Name and address of person	who completed cause of d		Print)		<u> </u>		
		•	31. Date filed (Month, Day, Year)	(AV 32. Registr	111 P	enn Street,	, Baltimore,	Mary	Land 2120	1
	Sta Registr				ever &	Soule				

ΙM			For	State of Maryland /			Mental Hygie	ne) nnl.	25016
			1 - Stete Registrar		Certificate of	Death	Reg.	No. UU4	35846
	Physici	an .	1. Decedent's Name (First, Middle, Las	11100010	SAVAGE		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	Street and number)	DAVAGE 4b. City. Town. o	or Location of Death		9, 2004 4c. County of Death	7:58 P M
	Examin	er	SINAI HOSPITAL	,		MORE CITY		N/	A
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	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	wn or Location				10d. Inside City Limits
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	h the	Director	10e. Street and Number		10f. Zip Code	/// 0/_	/10g.	Citizen of What Cou	intry?
	23e c	ai D	4648 PIM	LICO ROAL		2121	5	USA	,
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sr an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	72 hours after death with the Maryland naturel', or Items 23e or 28esf ehow Iteal Evandred must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 ☒No If Yes, Give Year or Dates:	1 ☐ Yes 2 💆 No	Specify:		Specify: 13	na il
00-	2 hou ature	ted t	15. Decedent's Ed	ucation 16a	i. Decedent's Usual Occup	pation	168	o. Kind of Business/Ir	ndustry
215	within 7. ene. then "n	Completed	(Specify only highest gra-	de completed) College (1-4 or 5+)	(Give kind of work done life. DO NOT use retire	during most of world)	king	,	٨
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Maryland 21215-0036	and Menial Is marke	Ţ O	19a. Informant's Name/Relationship (7	RANK DAVI	b. Mailing Address (Street	and Number or Bui	A Bhute Number C	TN 1000 State 1	n Code)
Ma	C C W W		SHIRLEY RO	VAI (MOTHER) 4	4648 PIM	4100 F	D. BA	170 MD.	21215
Jre,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of	of Disposition (Name of ery, crematory or other place		Date 200	. Location - City or T	own, State
imo	Part and		1, Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	MEM. PARK	11-1.	5-04 W	DODLAN	UN. MD.
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Euneral Service Licen	11, 20	22. Name and Addre	ss of Facility	ROWNJR	FUNERA	L Home
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	incations that caused the death. Do one cause on each line.					Approximate Interval Between Onset and Death
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	g Physier this	n: T	27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury Wor	y at	28d. Describe how i		97/
ior	Attending or death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	11904 7.3		Yes 2 ⊅¥yo	Subu	t shot	
Division	after deat Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office		28f. Location (\$ ree. City or Town, S	tand Number or Rura tate) 4100 Blo	al Route Number,
	urs af urs af sral D			Street			lowanda t	Ne Balti	MARCHD
	To the Mospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☑ Medical Exemone)	/sicien: To the best of my knowledg iner: On the basis of examination ar and manner stated.	nd/or investigation, in my c	me, date and place, ppinion, death occur	and due to the cause red at the time, date	(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
	- > - 0		· (aral H	relan nd	0 0	ME	NC	VEMBER 10	, 2004
	9		30. Name and address of person who o	ompleted cause of death (Item 23a)	(Type, Print) 111 T	Dann Str	ot Dol+4~	nno Mare	land 21201
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	Sta Registr		NOV 1 2 20	32. Registrar's Signature	& Spark	N			

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			1. Decedent's Name (First, Middle, Last)							2. Date of D	eath		3. Time of Death
	Physic /Medi		Edward Brian Sl	elton -	Edward 1	B. S	She1to	on S	r.		Novem	oer Da	5, 2004	1213 A M
	Exami		4a. Facility Name (If not institution, give						Location	of Death		40	. County of Dea	th
			I 95 North @ Rout					ridg				Н	oward	
	Funeral Director		5. Social Security Number 6. Se 215-74-4802 Usual Residence of Decedent	x 7. Ag 3M 2□ F 4	e (In yrs. last bir 7	thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 2-22-1	av. Ye <i>ar</i> l		thplace (State or Foreign ountry) Syland
	land ow		10a. State 10b. County		10c. City, Tow	n or Loc	cation							10d. Inside City Limits
	h the Maryland r 28e-1 show	ţ	MD Howard		Elkrid	ge								1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23a or 28e-1 show	Director	10e. Street and Number			0 -	10f. Zip	Code				10g. Ci	tizen of What Co	ountry?
	ath w	ral	7734 Washington Bl					075				U.	S.A.	
		Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. W	Vas Decede Yes, speci	ent of His	sp <i>a</i> nic Ori n, Mexicar	gin? (Sp n, Puerto	ecify Yes or Ne Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	a o	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	10	1	☐ Yes 2	Z€ No	Specify:				Specify: Wh	ite
9-0	2 ho	ted	15. Decedent's Edu	cation	16a.	Deced	ent's Usual	l Occupa	tion			16b. K	and of Business	/Industry
215	C	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give k	kind of worl OO NOT use	k done d e retired)	uring mos	t of work	ing			,
21	filed within Hygiene. Other then		10		Т	ruck	k Dri						eight	
Maryland 21215-0036	<u>\$ 6 5 5</u>	Be	17. Father's Name (First, Middle, Last) Stanley Shelton								e (First, Middle	, Maiden	Sumame)	
7	2 should be for and Mental lis marked of reumatic eve	2	19a. Informant's Name/Relationship (Ty	ne Print)	10h	Mailine	a Address	(Street o			erley	0:	or Town, State,	
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Janet Shelton/Wife										ridge M	
Je,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tre once.	١.	20a. Method of Disposition		20b. Place of	Dispos	ition (Nam	e of			Date		ocation - City or	
E O	Page nent o int: If	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State		-	atory or oth		·	11_1	1-2004	C1 a	n Burni	2.00
Baltimore,	permit. Departn Imports eny inju		21. Signalur of Funeral Service Liver-	Abrit	1/2.00	1 22.	Name and	d Address	of Facilit	V				
_	40 F 9 9	/	M Shirt March	Well !	Molda	27	719 Ha	e Fui ammoi	neral nds F	Hon'erry	re of L	ansd ansd	owne owne Md	21227
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Cow	the death. Do'n e. WESS (1) consequence of	020					or respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	death certificate be executed eattending physician and der use as the burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of									
9	tificat ng phy as the	ledio												
.O. Box	the y th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pre Other (spe						23d. Date of del Month	ivery Day Year
<u> </u>	requires that een signed b nould be deta	by Pt	Part II. Other significant conditions cor	tributing to death bu	it not resulting in	the unc	derlying car	use givei	n in Part I.		23e. Did t	obacco u	ise contribute to	the cause of death?
ırd	w require been sig should b	pe.									1 🗆 '	Yes 2	X(No 3□ Pr	obably 4 Unknown
Records,	law as b	Completed									24a. Was		24b. Were au	topsy findings available
<u>=</u>	Th ate pag	Con									autor perfo	rmed? 2 \(\sigma\) No	death?	completion of cause of 2 ☐ No
Vital	ystcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
of	Phys this al dii	2 ·	1 X Yes 2 No P	ospital: 1 ☐ Inpatier 28a. Date of Injur				-	4 🗆 IVUI				6X Other (Spec	eify) At Scene
	iding Ph Ih. : After th funeral	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) In	njury		c. Injury	es 2 🗆 N		Subjec		y occurred Co	ur landed on
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, far			_/\			28f. Location (Street an	d Number or Ru	ral Route Number, Bat R+160
	To the Hospitel or within 24 hours afte To the Funerel Diracompletely filled in I	Medical (29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☑ Medical Examin	ician: To the best of er: On the basis of and manner sta	examination and	death of	occurred a	the time	, date and nion, deat	d place, a	and due to the	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		1		29c.	License	number			29d. Dat	e signed (Month	n, Day, Year)
	ĺλ		· larde Ha	llanm	d		0.0	C.M.	E			Nove	mber 5,	2004
			CAROLH.A.	mpleted cause of de	ath (Item 23a) (,	enn S	Stree	t, E	altimo:	re, l	Marylan	d 21201
	Sta Registr		31. Date filed (<i>Month, Day, Year</i>) NOV 1 2 2004	32. Registra	r's Signature		lone	1/2/						

	1 - State of Maryland / Dep	partment of Health and Mertificate of Death	Mental Hygier	2001 05010
Physician	1. Decedent's Name (First, Middle, Last) Cecelia Rose Stewar	t	2. Date of Death Month November	3. Time of Death 5 2004 6:20 A. M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice	4b. City, Town, or Location of Death Baltimore	4	4c. County of Death N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 F 80 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea June 28,1	ar) 9. Birthplace (State or Foreign Country) 924 Maryland
Maryland P-f show	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 □ Yes 2Ã No
ath with the Marylar 23a or 28a-f show alst be routified at ral Director	10e. Street and Number 6 Patapsco Road	10f. Zip Code 21090	10g. (Citizen of What Country?
er de litems	If Yes, Give Year or Dates:	Usas Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify: White
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours after department of Health and Mental Hygiene. portant: If item 27 is marked other than "natural, or item y injury or other traumatic event, the Madical Examination. To Be Completed by Fune	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 15. Decedent's Education (Giv. Giv. ent's Usual Occupation e kind of work done during most of work DO NOT use retired) MEMAKET		Kind of Business/Industry Own Home	
aryland 2 should be filed ind Mental Hygin imatic event, II To Be Cc	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid es Pyle	en Sumame)
re, Maryla s 1 and 2 should of Health and Men of Health and Men other traumatic	19a. Informant's Name/Relationship (<i>Type, Print</i>) Mark Stewart / Son 3612		Baltimore,	Maryland 21229
Baltimore permit. Pages 1 Department of Hi Important. If itse any injury or oth	1 □ Burial 2 Cremation 3 □ Hemoval from State 1 □ Donation 5 □ Other (Specify) Bayview	ematory or other place) Crematory 11/6		Location · City or Town, State 1timore, Maryland
Balt permit Departi Import any inj once.	1 Hono aldridge	1001 Ritchie Highwa	ay Balti	al Service, P.A. more, Maryland 21225
STEWART 11/5/04 6 ²⁰ A Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and lapped 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	Sound field list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):	nter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death A MCW/THS
P.O. Box 6876. P.O. Box 6876. The death certificate be to be the attending physicis etached for use as the but physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
TEWART cords, P.O. I wrequires that the de speen signed by the a should be detached i	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	\ \v	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
I STEW !! Il Records, The law requires ! The law requires ! page 2 should be ! Completed by			24a. Was an autopsy performed?	
Sectory islon of Vite thanding Physician death. the funeral director ication: To Be	25. Was case referred to medical examiner? 1 Yes	ent 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in 28f. Location (Street	and Number or Rural Route Number,
Display of the control of the contro		ath occurred at the time, date and place,	City or Town, Sta	(s) and manner as stated.
To the Hospi within 24 hour To the Funan completely fill	(Check only one)	29c. License number		and place, and due to the cause(s) Date signed (Month, Day, Year)
	30. Name and a cross of person why completed cause of death (Item 23a) (Type	DOO 22488 MBRIDGE RORD ;	//	-5-04
State Registrar	31. Date filed (Mopth, Pay, Year) NOV 1 2 2004 2. Registrar's Signature	NBRIDGE FORP;	BALTIMOR	RE, MD, 2/2/2

Amend item#12, periff, 6837,11/16/04 TI

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** JAMES DONALD SMITH 7 2004 4c. County of Deeth /Medical November 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER Baltimore County Towson
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 □ M 2 😾 F 86 Director 507-10-9500 Aug 16, 1918 Nebraska Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or Itema 23a or 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore County Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6104 Buckingham Manor Drive filed within 72 hours after death v Hygiene. Funeral 21210 USA 12. Was Decedent Ever in U.S. Armed Forces? 42–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 X If Yes, Give X Year or Dates: 1 Never Married 2 Married
3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify: Specify: White "naturs!" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) US Dept of Defense permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: if Item 27 is marked other that any injury or other traumatic avant, Imaliany injury or other traumatic avant, Imaliany injury or other traumatic avant, Imaliany injury or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant, Imaliany or other traumatic avant. Policy Officier 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward Smith Thomas Anna Dewey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21210 Olive M. 20b. Place of Disposition (Name of Cametery, crematory or other place) Smith (Wife) Baltimere, Maryland 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery 11/9/2004 Baltimore, Maryland 21. Signature of Fungral Service User ee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

21212

22a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ocas a consequence of). Examiner burial-transil Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ło Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þe 3 ☐ Probably 4 📆 Onknown 1 Tyes 2 No been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 🗌 Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of After Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after deat Funeral Director: in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 20649 owce mu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Bowie, 31. Date filed (Month, Day, Year) 6701 North Charles Street, Towson, Maryland 21204 M.D. 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 2 2004

				For State Registrar	State o	of Mar	ryland / De	epartment o	of He	ealth and N	Mental Hy	giene ()	04	35850	
				Decedent's Name (First, Middle, Las	1)					-	2. Date of Dea	ıth		3. Time of Death	_
	4	Physici: /Medic		Paul Lamar Shrive	r						Novembe	r 8	2004	12:20PM	
		Examin		4a. Facility Name (If not institution, give	street and nu	ımber)				ocation of Death	l		nty of Death		
				Gilchrist Hospice 5. Social Security Number 6. Se		7 400	(In yrs. last birtho		son	If Under 24 Hrs.	9 Date of Birt		timore		
		Funeral Director			X M 2□F	7. Age (83 Yr	Months D	ays	Hours Min.	8. Date of Birt. (Month, Day October	7,192	1 Ter	lace (State or Foreign ltry)	
				Usual Residence of Decedent		1					peroper	79172			_
		arylar show	-	10a. State 10b. County Maryland Baltimor		1	10c. City, Town o						1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No	
		the M 28a-f	ecto	Maryland Baltimor 10e. Street and Number	е		Dail	10f. Zip Co	do			10g. Citizen	of Milhar Cour		_
		with 3a or	Funeral Director	7105 Sheffield Rd.				212				•	ed Sta	,	
		death	nera	11. Marital Status	12. Was Dec	edent Ev	er in U.S.	13. Was Decedent If Yes, specify	of Hisp	panic Origin? (Sr	pecify Yes or No-	14. F	ace - Americ		_
	92	after or ite	/ Fu	1 ☐ Never Married 2 X Married	1 X Yes If Yes. Gi	2 □ No ive		1 ☐ Yes 2 🔯		Specify:	mican, etc.)		lack, White,		
	Ö	hours tural',	ed by	3 Widowed 4 Divorced	Year or E	Dates: V	WII						oity: whi		_
	15	n "na"	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		(0	ecedent's Usual O Give kind of work d fe. DO NOT use re	ccupati lone du etired)	ring most of worl	king	16b. Kind of	Business/Ind	dustry	
	212	d with giene ar tha	mo	Elementary/Secondary (0-12)	College (5+	(1-40r 5+)		attorney				oil c	ompany	/real esta	t
	pu	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)					1	8. Mother's Nam Ida Br	ne (First, Middle,	Maiden Sum	ame)		
	Zla	Men A Men narke	ို	Paul Shriver	Orient		405.1					0: =			
3	altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinal must be notified at once.		19a. Informant's Name/Relationship (7 Kirk Shriver/son	ype, Print)		603	Dunkirk	Rd.	Balt	imore, 1	$\stackrel{\text{r. City of Tow}}{\mathbb{D}}$ 212		Code)	
150 pm	ore	of He of He If item or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from			isposition (Name of crematory or other			Date	20c. Locatio			Ī
2	ţ.	t. Pag tment tant: tant:		'4 ☐ Donation 5 ☐ Other (Specify)		Dulaney	Valley Me							
-	Bal	permii Depar Impor any ir		21. Signature of Funeral Service Licens Ookin 0. Mittee	hell !		1	22. Name and A Mitc 650(chel Yo	li-Wiede ork Rd.	feld Fur Baltin	neral l	Home, MD 21	Inc. 212	
+				23a Part1. Enter the disease, or components of the components of t	lications that	caused the	ne deeth. Do not	enter the mode of	dying,	such as cardiac	or respiratory are	est,		Approximate Interval Between	
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20		/Medical Examiner		resulting in death)	Due to	(or as a	consequence of)							104.6	
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61	v.tv	uted d ansit	Examiner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,								
tember ,	0	cate be executed obly sician and the burial-transit	Еха	resulting in death) Last	Due to	(or as a o	consequence of):								
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3	9	ertific ding pl	/Med	IF FEMALE:	77a Huna av	tramp of			-				-		
2	Box	the death certificate y the attending phys Iched for use as the	Physician/Me	in the past 12 months?		birth 2	pregnancy □Fetal death ne of death	3 ☐ Ectopic pregn					ate of delive Month	ry Day Year	
	0	uires that the designed by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		ne or death	J Ciller (Specif)	y/						
7	٣.	requires that een signed b nould be deta	by P	Part II. Other significant conditions co	ntributing to d	leath but	not resulting in th	e underlying cause	e given	in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of death?	1
Es	rds	w require been sig should b									1 □ Y	es 2 🗆 No	3 Prob	ably 4 Unknown	ı
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NU	Vita	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:						th (Check only or	Via:		TITLE C	
	o To	Phys r this ral dir	. To	1 Yes 2 No	1 🗆	Inpatient of Injury			Other:	4 Nursing no	ome 5 ☐ Reside			nospice	_
5	on	Attending r death. ector: After y the fune	tion	1 Natural 5 ☐ Pending investigation	28a. Date (Mon	nth, Day Y	/ear) Inju		Injury a Work? 1 Ye	s 2 🗆 No		or injury out	31100		
<()	Division	Attendi er death. ector: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	e of Injury	- At home, farm	, street, factory, off	fice		28f. Location (S. City or Town	reet and Nur	nber or Rura	Route Number,	
	Ö	ital or irs afte ral Dir led in	Cert		Julia	ing, etc.	(3)			Ŋ	Ony or 10 W	r, State)			
		To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	iner: On the b	e best of a pasis of ea oner state	xamination and/c	eath occurred at the investigation, in r	ne time, my opin	, date and place, nion, death occur	and due to the c red at the time, d	ause(s) and r ate and place	manner as st e, and due to	ated. the cause(s)	
	_	To the within To the compl	Me	29b. Signature and title of certifier	0		^	29c. Lic	cense r	number	2	9d. Date sigr	ned (Month, L	Dey, Year)	-
				Maran	1	- V	W)	D	5	8303	(Joven	Wer 8	2004	
		0		30. Name and address of person who o	ompleted cau	se of dea	th (Item 23a) (Ty		n	arles S	or Bal	tonore	e MO	21204	
		Sta		31. Date filed (Month, Day, Year)	32. F	Registrar's	s Signature								
		Registr	ar	NOV 1 2 2004	Side	marine	v B	Spork	21						

			Tor State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of He tificate of D	ealth and M Death		giene 0 4	35851
	Physici		1. Decedent's Name (First, Middle, Last) Regina Magdaline	Schenning	_	- 10 mm		2. Date of Dea Month	ath Day	Year Or 4 11', 10 0 M
	/Medic Examir Funeral		4a. Facility Name (If not institution, give str	. 11	1 () ist birthday)	4b. City, Town, or I	e) e If Under 24 Hrs.	Grace 8. Date of Birth	4c. County o	of Death Provid 9. Birthplace (State or Foreign
	Director		215-13-6967	4 2⊠F 82	Yrs.	Months Days	Hours Min.	(Month, Day Dec. 7		Maryland
	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If term 27 is marked other than "netural", or items 23a or 28a-f show any injury or other treumatic event, I.e. Medical Exercit or it and be rediffed at once.	tor	10a. State 10b. County Maryland Harford		Town or Lo Bel Ai					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Funeral Director	10e. Street and Number 2816 Calvary Road			10f. Zip Code	1.5		10g. Citizen of Wh	•
	death y	neral		. Was Decedent Ever in U.S Armed Forces?	i. 13. y	210 Vas Decedent of His Yes, specify Cuban		ecify Yes or No-	USA 14. Race	- American Indian,
36	irs after II', or Ite	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1	Yes 2√2 No	Specify:	nican, etc.)	Specify:	, White, etc. White
5-0	"neture	leted	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Deceo	lent's Usual Occupat kind of work done du DO NOT use retired)	ion iring most of worki	ing	16b. Kind of Bus	
212	d withir giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen				Own Hom	e
Maryland 21215-0036	d be file ental Hy ced oth	Be	17. Father's Name (First, Middle, Last) Henry (NMN) Schenni	na			18. Mother's Name Barbara		Maiden Sumame,)
ary S	2 shoul and Me Is mark	To.	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street ar				tate, Zip Code)
ē.	s 1 and Health Item 27 other tr		Helen E. Schenning 20a. Method of Disposition	In-Law	ce of Dispo	Calvary sition (Name of satory or other place	,			ity or Town, State
altimore.	Pages tment o tant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer `4 ☐ Donation 5 ☐ Other (Specify)	Sacr	ed Hea	art of Jes	sus 11-10		Dundalk,	, MD
Ball	permit Depar Impor any in		21. Signature of Funeral Service Licensee	rge /	22 Mo 1.	Name and Address COMAS Fur 317 Cokesh	of Facility neral Hon oury Road	ne, P.A.	rdon MD	21009
	Observatoria		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	rons that caused the death, eause on each line.	Do not ente	er the mode of dying,	such as cardiac o	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	ence of):	THE				
	Examiner	ler	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					
- *	ecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ance of\-					-
N R. 8760.	cate be executed physician and the burial-transit	dicalE	d.	220 10 (01 20 2 001)00421						
O. Box 68	h certifii ending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of pregnan 1□Live birth 2 □ Fetal of 4□ Pregnant at time of dea 9□ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Month	
Cds. P	quires that in signed build be deta	by	Part II. Other significant conditions contri	buting to death but not resul	ting in the ur	derlying cause given	in Part I.			ute to the cause of death?
1 mg)	The law requirate has been sipage 2 should	Completed						24a. Was a autops perform	sy prid med? dea	ere autopsy findings available or to completion of cause of ath?
۱۳۸۸ Vital	Physicien: this certific	o Be (25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	pital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient		26. Place of Death			(00-00)
ハモかがい on of Vital Re		\vdash	27. Manner of Death	The second secon	28b. Time of Injury	28c. Injury a Work?	at 2		ence 6 Other ow injury occurred	
こらか Division	or Atten ifter deat Director; in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre		es 2 🗆 No	28f. Location (SI City or Town	treet and Number n, State)	or Rural Route Number,
O) -	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only one) (Check only one)	ian: To the best of my know r: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time estigation, in my opin	, date and place, a	and due to the ca	ause(s) and mann ate and place, and	ier as stated. d due to the cause(s)
	To the within :	Me	29b. Signature and title of certifier	To all		29c. License	number 4780	2	9d. Date signed (Month, Day, Year)
	X		3/9 Set person who com	pleted cause of death (Item)	23a) (Tyr)8, F	Print) Mal	21078		1/4	191
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 2	32. Registrar's Signatu	re /	& Spa	uhs/	-		

			1 - For State Registrar	State of Mary		artment of ertificate of			ene g. No.200	4 35852
f	Physic /Medi		 Decedent's Name (First, Middle, Las Michael Totten 	")				2. Date of Death Month October	Day Ye	ar 1:31 PM M
- Salar	Exami		4a. Facility Name (If not institution, give Southern Marylan			4b. City, Town, Clinto	or Location of Death	1	4c. County of D	
Ė	Funeral Director		5. Social Security Number 577-62-5682 Usual Residence of Decedent	'	yrs. last birthday 5 Yrs.	Months Days		8. Date of Birth (Month, Day,) Oct 28,	^(ear) 1948	Birthplace (State or Foreign Country) unk
	a-fahow	ctor	10a. State 10b. County	George's	C. City, Town or L Upper	ocation Marlboro				10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 9115 Marlboro Pik	es Lot 3		10f. Zip Code	20745	10	g. Citizen of What USA	
039	n 72 hours after death with the Maryland "natural", or trams 23a or 28a-1 ahow offed Examirer must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	in U.S. 13. unk	Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		merican Indian,
	y within piene. r than	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) unk	ucation le completed) College (1-4or 5+) ink	(Give	edent's Usual Occu e kind of work done DO NOT use retire	during most of wor	king unk 16	6b. Kind of Busine	unk unk
	should be filed void Mental Hygie warked other i	To Be C	17. Father's Name (First, Middle, Last)		,	unk	18. Mother's Nam	ne (First, Middle, Ma	aiden Sumame)	un
	ss 1 and 2 sh of Health and itam 27 la m othar traum		19a. Informant's Name/Relationship (T. Southern Maryland 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Hospital Removal from State	750 Ob. Place of Disp	3 Surrat	ts Road C	linton, M		
	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 🖔 Other (Specify 21. Signature of Funeral Service Licens				ess of Facility tomy Board		Baltimore	e Street
	nysician /Medical Examiner		23a. Part1. Exter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the ne cause on each line. a. Due to (o as a core	death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
		Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cor						
.O. BOX 66/00,	law requires that the death certiticate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	□Ectopic pregnand □ Other (specify) _	зу		23d. Date of o	delivery Day Year
L (20)	w requires that been signed b should be det	by	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	inderlying cause gi	ven in Part I.	23e. Did toba	-	o to the cause of death? Probably 4 Unknown
	The ate h page	Completed						24a. Was an autopsy performa	prior 1	
5	Attending Physician: In rideath. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Natural 5 Pending investigation	Hospital: Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	of 28c. Inju	her: 4 Nursing Ho	th (Check only one) ome 5 Aesidence 28d. Describe how		oecify)
DIVISION	tal or Attendir s after death. al Director: Af ed in by the fur	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
	I o the Hospital or, within 24 hours after To tha Funaral Direction completely filled in E	edical	29a. Certifier (Check only one) 2 Medical Exam	sician: To the best of my ner: On the basis of exal and manner stated.	knowledge, deat mination and/or in	vestigation, in my	opinion, death occur	and due to the causered at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
	To t	Σ	29b. Signature and title of certified	Dumais Ms)	29c. Licen:	se number 53813		. Date signed (Mo	
	1369-E-1		30. Name and address of person who co	ompleted cause of death R.MD. 750	(Item 23a) (Type, 3 Surva	Print) HS RJ. [-linton, a	10. 2073.	5	
:	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 2 2004	32. Hegistrar's S	orgnature &	Sparks	1			

			1 - For State Registrar	State of Maryland	/ Department of Certificate o			ne 2004	35853
	Physici		1. Decedent's Name (First, Middle, La	MARSHELL	TAVIO	R	2. Date of Death Month	Day Yeer 7 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gire			, or Location of Death	1404, 0	4c. County of Death	0107/r.
			3826 BEEI	HLER AVENU		BALTIMO	DRE	NI	7
	Funeral Director		579-62-0520	Sex 7. Age (In yrs. las. 57	t birthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, ye SEPT, 12,	9. Birthol County 1947 WAS	lace (State or Foreign try)
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	own or Location		~	10	Od. Inside City Limits
	death with the Maryland ms 23e or 28e-1 show crivest by nutilized at	Director	MARYLAND NI	4	10f. Zip Code	TIMORE		Citizen of What Coun	1 Yes 2 No
	3e or		3826 BEE	HIFD AVEN	11 E	2121	5	(15A	ll y r
	after death w	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent o	f Hispanic Origin? (Spe uban, Mexican, Puerto	cify Yes or No-	14. Race - America Black, White, e	
020		by Fu	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	1 M Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2KN		noan, otc.,	Specify:	A 7 1/
5	72 hours "natural",		15. Decedent's E	ducation	6a. Decedent's Usual Occ	upation	168	b. Kind of Business/Ind	HC/C Justry
7		Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use reti	né during most of worki. red)		1 2	
7	be filed withir tal Hygiene. d other then event, Ire M.		17. Father's Name (First, Middle, Las.	1)	CUSTO	18. Mother's Name	(First, Middle, Mail	HUTO RE	PAIR
	nould be I Mental narked o	To Be	WILLIAM	TAYL	OR	ROSE		Rosco	; E
	and N le ma	-	19a. Informant's Name/Relationship		19b. Mailing Address (Stre	et and Number or Rura	l Route Number, C	7 10 0	
S S	and 2 Health am 27 her tr		MARCEL ENA MOOR 20a. Method of Disposition		382688 e of Disposition (Name of	EHLER AV		THORE, MI	
	ages int of h t: If ite		1. Burial 2 ☐ Cremation 3	Removal from State	etery, crematory or other p	1 1		. Location - Oity or Tox	
Dallimor	permit. Page Department of Importent: If Imy injury or once.		'4 □Donation 5 □ Other (Special21. Signature of Funeral Service Lice	nsee	RISON FORE 22. Name and Add	Iress of Facility BR	007 00	. FUNERA	
ŏ	permit. Depart Import any inj		Dietrich	V. William.	2140N	- FULTON	AVE, X	SALTO.M.	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	pplications that caused the death. I				/	Approximate Interval Between
:	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. PULMON	my popi	ENO CAR	CINCAN,	A	Onset and Death
	Examiner			Due to (or as a consequen	ice of): #			/	
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	ice of):				
	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ice of):				
00/0	cate be executed hysician and the burial-transit	dical E	(ê d					
0	ntificati ng phy as the	Medi	IF FEMALE:						
א מ	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	ath 3 Ectopic pregnan			23d. Date of deliver	y Day Year
5	the de y the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death	h 5 ☐ Other (specify)				
'n	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Pł	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause o	given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
Spico	require een si	ted					1 Tes	2 No 3 Proba	ably 4 □Unknown
מ	has b	Completed					24a. Was an autopsy performed	prior to com	sy findings available pletion of cause of
g	ilcien: The lav certificate has rector, page 2	e Co	25. Was case referred to meglical			26. Place of Death	1 ☐ Yes 2 ☐		2 □ No
>	Physicien: this certifica ral director, j	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3□ DOA	ther: 4 Nursing Hon		e 6 □Other (Specify))
	ing Pt Viter th uneral		27. Manner of Death 1	(Month, Day Year)	b. Time of lnjury 28c. lnj		8d. Describe how in	njury occurred	
2	Attend death ctor: / y the f	llcat	2 Accident investigation 3 Suicide 6 Could not to	De Diese of triver. At home		Yes 2 No	8f. Location (Street	t and Number or Rural	Route Number
2	s after s after el Dire ed in b	Certification:	4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, Si	tate)	770710 77071007,
	To the Hospital or Attending Physicien: The law within 24 butus after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Pi (Check only one) 2 Medical Exe	hysicien: To the best of my knowle miner: On the basis of examination and manner stated.	dge, death occurred at the and/or investigation, in my	time, date and place, a opinion, death occurre	nd due to the cause od at the time, date	e(s) and manner as sta and place, and due to t	ted. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. Lice	se number	29d.	Date signed (Month, D	ay, Year)
			· An	modro	no 1	15140		11/19/24	>
7	λ'		30. Name and address of person who	completed cause of death (Item/33	(Type, Print)	ATTYCK ,	H5 Are	BAR	MA
	Sta		31. Date file NOVINTO 2 Y 2004	22. Registrar's Signature	I hone	1100	/-/-	1 1011	4770
	Registr	ar			and sources	1		<i>()</i>	6/03

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cel</i>	artment of rtificate o	f Health ai of Death	nd Mental H	ygiene 2 (104 35	854
	Physic /Medi		1. Decedent's Name (First, Middle, Las	TRIBBL	E			2. Date of D Month	eath Day	Year 2004 4:1	f Death
	Exami		4a. Fecility Name (If not institution, give St. Agnes Hos) 5. Social Security Number 6. Se	oital x 7. Age (In yrs.	last birthday)	Balt:		Death 4 Hrs. 8. Date of 8	4c. Count	of Death	or Foreian
	Director		220-20-5550 Usual Residence of Decedent 10a, State 10b, County	□ M 2XF 93	Yrs.	Months Day	ys Hours	Min. (Month, L 2-22	Day, Year) -11	Abbevill	e,SC
	n the Maryl r 28a-f eho notified a	irector	Md. N/A		Baltin		9		10g. Citizen of	10d. Inside Ci	-
980	ages 1 and 2 should be filad within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or itams 23a or 28s-1 ehow or other fraumatic event, the Mailcel Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married **Widowed 4 Divorced	AVC. 12. Was Decedent Ever in U Armed Forces? 1 □ Yes. 2 ▼No If Yes, Give Year or Dates:		212 Was Decedent of Yes, specify Co	of Hispanic Origi uban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	USA lo- 14. Rac Bla	e - American Indian, ck, White, etc.	
21215-0036	filad within 72 he Hygiene. kther than "natu ent, Ine Madical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ication le completed) College (1-4or 5+)	(Give	lent's Usual Occ kind of work dor DO NOT use reti	ne during most o ired)	of working	16b. Kind of B	usiness/Industry	
Maryland	2 should be fill and Mental Hy is marked oth sumatic event	To Be	17. Father's Name (First, Middle, Last) Samuel L. Per 19a. Informant's Name/Relationship (T)	nnell_ vpe, Print)	19b. Mailin	g Address (Stre	Par	s Name (First, Middle alee Moor Rural Route Number 1)	oragne		
Baltimore, M	perrit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or othar tre ones.	3	Nellie Maxine 7 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. P Removal from State	lace of Disposemetery, cren	Glenro sition (Name of natory or other p	lace)	e,Baltimo	20c. Location -	vland. 21 City or Town, State	1208
Balti	perriit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens Lloyd M. Est	ee PD	22 F 1	Name and Add	ress of Facility Prother Itaw Pl	s Funer	al Ser,		7
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp. shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a. COMPLET Due to (or as a consequence)	= H: 9 71	EART	BLOCK		arrest,	Approximate Interval Betwood Onset and E	ween Death
O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Medical Ex	FEFEMALE:	Due to (or as a consequent). 3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of degree Unknown	ncy death 3	Ectopic pregnan Other (specify)	icy		23d. Dat Moi	e of delivery th Day Y	'ear
ords, P	w requires tha been signed I should be det	by	Part II. Other significant conditions con	2F	ulting in the un	derlying cause g	given in Part I.			ibute to the cause of de	eath? Inknown
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Division	To the Hospital or Attendit within 24 hours after death. To tha Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	"			City or To	wn, State)	r or Rural Route Numb	ner,
	thin 24 ho thin 24 ho tha Fune mpletely fi	Medical	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one) 2 Medical Exemination (Check only one)	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	estigation, in my	time, date and p opinion, death o	lace, and due to the occurred at the time,	date and place, a	nd due to the cause(s)	
)	F 3 F 8		30. Name and address of person who co	IK hy	230) 75	000	06176	5		(Month, Day, Year)	4
	Sta Registr	te	31. Date filled (Month, Pay Year)		S HEA	LTH CAN	F 900	CATON A	UE BALT	imore MD	

TRIBBLE, EUNICE

	1	CHARLIA	Last)	TE	ROY	CR		Month	Day O4	Yeer	3. Time of Death
ledica aminei		4a. Facility Name (If not institution, g	ive street and numb	oer)		4b. City, Town, or Location			4c. County	2004 of Death	
		2542 PARK	< Heig	HTS '		BALTIMOR If Under 1 Year If Under		Δ		th'mo.	
eral etor		241 42 8983	Sex. 7.	Age (In yrs. la	Yrs.	Months Days Hours	Min.	B. Date of Birth (Month, Day		Cour	place (State or Fore
	_	Usual Residence of Decedent 10a. State 10b. County	./.	10c. City,	, Town or Loca	ation				1	0d. Inside City Lim
potos	Joha	MD N	1/A		BACT	IMORE	C	TTY	,		1 1 1 es 2 🗆
Funoral Director	10 10 10 10 10 10 10 10 10 10 10 10 10 1	10e. Street and Number	HERE	175	Tes	10f. Zip Code	15		log. Citizen of	What Cour	ntry?
nou	Juer	11. Marital Status	12. Was Decede	ent Ever in U.S	3. 13. W	as Decedent of Hispanic O Yes, specify Cuban, Mexica	rigin? (Spec	ify Yes or No- ican, etc.)		ce - Americ	
ž	2	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 12 fes 2 If Yes, Give Year or Date	□No es:	1	Yes 21 No Specify			Specif		BIACK
poto	Completed	15. Decedent's (Specify only highest g			16a. Decede	ent's Usual Occupation ind of work done during mo O NDT use retired)	st of working	9	16b. Kind of B	usiness/Inc	dustry
4	duo	Elementary/Secondary (0-12)	College (1-4	or 5+)	MANA	ONDT use retired)	DE RA	1-mR	E35/	144	MEAT
a	e n	17. Father's Name (First, Middle, La	st)	711		18. Moth	ner's Name	First, Middle,	Maiden Suman	ne)	2
F	0	19a. Informant's Name/Relationship	(Type Print)	09	10h Mailing	Address (Street and Numb	ARK	TE	Ple	AK	SON
		SERETHA T	ROY /U	THE	154	2 PAN H	eache.	Tea.	134C	51a10, 21p	ND 2/2/
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from Sta		ace of Disposi metery, crema	ition (Name of atory or other place)	D Da	te	20c. Location	City or To	wn, State
	1	 4 □ Donation 5 □ Other (Spec 21. Signature □ Oneral Service Lice 	oify)	GA	RR150	ON FOROST Name and Address of Facil	NOV	12,200	1 Ou	lings	Mills M
OUC		21. Signature of Hutleral Service Cit	A. A.	Ju	4	(A) CIBEO	W 400	WETL KUTS	Alm	6417	- HOME
	_	II IN MINE.	111	7			/ /0	211	010	7-	-/ 1.12
		23a. Part Enter the disease, or co shock, or neart failure. List on	mplications that cau ly one cause on eac	sed the death.	Do not enter	r the mode of dying, such as	s cardiac or	respiratory arr	est,		Approximate Interval Between
		Immedia ause (Final diseal or condition	a. LUN	G CAT	vcer,	r the mode of dying, such as	_	respiratory arr	est,		Approximate Interval Between Onset and Death MoNHUS
1		Immedia ause (Final disea or condition resulting in death)	a Lun Due to (or	-	vcer,		_	respiratory arr	est,		Interval Between Onset and Death
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Certificate of Death

Towson

7. Age (In yrs. last birthday)

95

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

2. Date of Death

November 8

Month

8. Date of Birth (Month, Day,

1 - For State Registra

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Gilchrist Center

5. Social Security Number

216-46-7362

Leila Rutherford Turk

4a. Facility Name (If not institution, give street and number)

1 ☐ M 2 💢 F

35856 3. Time of Death 3:05 A M 2004 4c. County of Death Baltimore Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? United States 14. Race - American Indian. Black, White, etc. Specify: white 16b. Kind of Business/Industry own home 20c. Location - City or Town, State 2 now 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

29d. Date signed (Month, Day, Year)

heles it Baltimore

DHMH 17 Rev 1/2001

3

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 1 2 2004

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

TRUES

32. Registrar's Signature

			For State Registrar	State of Ma	aryland / Dep	ertificate of		and Me		/ 11	04	35857
		и	Decedent's Name (First, Middle, La	st)		Timeate of	Death	2	Rag. , Date of Death	No.		3. Time of Death
н	Physici /Medio		FRANCIS C	HARLES TIC	НА			NO	Month VEMBER	Day 9, 201	Year ZL4	6:08F M
	Examin		4a. Facility Name (If not institution, given the second		Center	4b. City, Town, o	man dia			4c. County		ms 4m 600 5000 9
		и						OWSO]	Balt	imore
	Funeral Director		5. Social Security Number 6. S	Sex 7.Age ISTM 2□F	e (In yrs. last birthda) 81 Yrs.	Months Days		Min.	Date of Birth (Month, Day, Ye		9. Birthpl Coun	lace (State or Foreign try)
			219-18-9282 Usual Residence of Decedent		01				Oct 23,	1923	Mar	yland —
	show	_	10a. State 10b. County		10c. City, Town or	ocation					10	Od. Inside City Limits
	Ba-f s	Director	Maryland N/A		Balt	imore Cit	у					1 Yes 2 No
	with t		10e. Street and Number			10f. Zip Code			10g.	Citizen of W	hat Coun	try?
	ns 23	erai	1345 Walker Ave	nue 12. Was Decedent B	Ever in U.S. 13	. Was Decedent of H	1239 Hispanic Orio	nin? (Specif	v Yes or No-		SA · America	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. The Madical Examines must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican,	, Puèrto Ric	an, etc.)		, White, e	
Maryland 21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dec	edent's Usual Occup e kind of work done	oation	of working	161	. Kind of Bus	siness/Ind	lustry
2	ithin see.	npie	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retire	d)	or working			_	
2	Hygier Hygier Ther th		12 17. Father's Name (First, Middle, Last)	De	eputy Chi		rle Namo /6				Fire Dept
and	d be f	To Be	Joseph	Tic	L				First, Middle, Maid			
37	shoutd ind Men s marke umatic	F	19a. Informant's Name/Relationship (ing Address (Street		lary r or Rural R	loute Number, Ci	y or Town, S		Code)
_	and 2 salth a n 27 ls		Charlotte L. Tic	ha (Wife		Walker						
Baltimore,	es 1 g of He fitam r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp	osition (Name of amatory or other place		Date		Location - 0		
Ĕ	Pages Iment of I tant: If it		*4 Donation 5 ☐ Other (Special	(y)	MD Veter	ans Cemet	tery 1	1/15/	2004 Ga	rison	Fore	est. MD
Ba	permit. Departn Imports any inju		21. Signalus of Funeral Service line		1	22. Name and Addre	ss of Facility	/				
	202.00		23a. Part1. Enter the disease, or com-	WSON	the death. Do not a	500 York	Road	Balt	imore. N	laryla	nd 21	212 imate
10			Immediate Cause (Final	one cause on each lin	θ.							Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		RESPIRAT	URY DIS	TRESS	SYN	DROME			
	Examiner		Sequentially list conditions,	PNEUMO								
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):							
	cate be executed physicien and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):						-	
8760,	e be e	dicai E		d								
9	tificat ng phy as the									-		
Вох	leath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		□Ectopic pregnancy	,			23d. Date		,
	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	1 Yes 2 No	4☐Pregnant at i 9☐Unknown		Other (specify)				Mont	n L	Day Year
P.0	res that the de signed by the a i be detached t	/ Ph	Part II. Other significant conditions	contributing to death bu	It not resulting in the	underlying cause giv	en in Part I.		23e. Did tobaco	o use contrit	oute to the	e cause of death?
Vital Records,	w requires been sign should be	d by	CHRONIC MYELO	GENOUS LEUR	KEMIA				1 🗌 Yes	2 No 3	B ☐ Proba	ably 4 🗆 Unknown
000	awre s bee 2 sho	Completed							24a. Was an	24b. W	ere autop	sy findings available
ž		Com							autopsy performed 1 Yes 2	de	ath?	pletion of cause of
/Ita	ysiclan: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?				26. Place	of Death (C	theck only one)			/
	Physi this o	Ţ	1 Yes 2 No	Hospital: 1 Inpatier		-	4 🗀 1401:		5 Residence			
uo	ding I h. After funer	tion	27. Manner of Death 1 Natural 5 Pending 1 Accident investigatio	28a. Date of Injun (Month, Day	Year) 28b. Time Injury	Wor	yat k? Yəs 2.⊡N		. Describe how in	lury occurre	d	
Division of	I or Attanding later death. Diractor: After in by the funer	ifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ry - At home, farm, s				Location (Street	and Number	or Rural	Route Number,
á	s afte	Certification;	4 Homicide	building, etc.	. (Specify)				City or Town, St	ate)		
	To the Hospital or Attanding Physician: The thin 24 hours after deals after deals To the Funaral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1	ysician: To the best o niner: On the basis of and manner stat	examination and/or i	th occurred at the tin nvestigation, in my o	ne, date and pinion, death	place, and n occurred a	due to the cause at the time, date a	(s) and mani and place, an	ner as sta id due to t	ted. the cause(s)
	To th To th comp	Ň	29b. Signature and title of certifier		//	29c. Licens	e number			Date signed		
	13	′	· Ma			D308	263			1-09	1-0	7
	1		30. Name and address of person who		ath (Item 23a) (Type	, Print)						
£ . 76	Šta	te	FRANCIS KHOO M	. D. 76 21	OSLER D		ISON.	MARY	4 AND 2	1274		
	Registr		NOV 1 & 2004	Deray	P M	oaks!						

State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registrar 35858 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 6, 2004 **Physician** 1709 Joseph Vincent Trovato Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bouth More 4c. County of Death **Examiner** NA Good Samaritan Hospitai If Under 1 Year | If Under 24 Hrs. 7. Age (in yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 1,1917 5. Social Security Number 9. Birthptace (State or Foreign 6. Sex **Funeral** 1 2 F Months Days Hours Maryland 213-28-1512 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other then "neturel", or items 23a or 28e-f show other treumetic event, the Madical Examinar must be multilled at 1 Yes 2 No Maryland | Baltimore Parkville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 U.S.A. 2804 Glavin Way Apt. B by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: If Yes, Give Year or Dates: WW 11 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) US Post Office 12 Asst. Post Master 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Mental Antonio Trovato Mary Recupero 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health 2804 Glavin Way Apt. B Baltimore, Maryland 21234 Mrs. Rita Trovato (wife) Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If eny injury or once. Dulaney Valley Mem. Gdn. 11/10/04 Timonium, Maryland A □ Donation 5 □ Other (Specify) ²²Mitchell-wiedefeld F.H. Inc. 21. Signature of Funetal Service L 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical use as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 2 No 1 Yes Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Injury at Work? After Hospitel or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funerel Director: A investigation 2 Accident 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🕰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 1)41536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blud Baltimore, MD 21239 MIVZa 31. Date filed (Month, Day, Year) NOV 1 2 2004 32. Registrar's Signatur State Registrar

Amend item4a, per MD, G837, II / 12/04 TT State of Maryland / Department of Health and Mental Hygien Cortificate of Death 35859 1- State Certificate of Death Registrement ITEM #12 PER FH C837 11/23/04 JII Reg. No. 2. Date of Death 3. Time of Death Month Day Year **Physician** 2001 november /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford & Upper Chesapeake Health Center If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days 218 40760 1 XM 2□ F 61 Yrs. 10,1943 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28e-f show count be notified at Harford 1 Yes 2 No macyland Edgewood Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Street U.S.A 2/040

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status other traumatic svent, the Mudical Experient 1 XX 2 2 2 No 1960— If Yes, Give Year or Dates: 1066 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 1966 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver Truck mstruction 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be is marked of Eugene Vaught Mae Grook Norothi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son R Vaught 1254 Reachtree Rd Daytona Beach William 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Pages I Department of F Importent: If Ite any Injury or ott once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Greenmount Cremation. 11 4104 curring 12.

22. Name and Address of Science St. Ballimore MC

119-121-South Stricker St. Ballimore MC

Approximation in Stricker St. Ballimore MC

Approximation as Cardiac or respiratory arrest, Interval B Baltimore Maryland 21. Signature of Funeral Service Licensee St. Ballimore MO 21223 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS 12 DAYS **Physician** /Medical Due to (or as a consequence of) **Examiner** BOWEL ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ENTERO COLITIS DIFFICILE burial-transit Due to (or as a consequence of): Box 68760, that the death certificete be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 WNo 1 ★ npatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29c. License number nhen Novalemista NOVEMBER 3,2004 D08096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 125 N. MAIN ST. PEZATR, MD21014 NOW AKOWSE (32 Registrar'a Signature State Registrar

		For State Registrar	State of Ma	aryland		rtment of H	Health and M Death		giene Neg. No.	004	35860	
Physician /Medical		1. Decedent's Name (First, Middle, La Tijwana	st)			Williams		2. Date of Dea Month	Day	2004 Year	3. Time of Death 2:30p M	
Examir		4a. Facility Name (If not institution, give street and number) Joseph Ritchie Hospice			4b. City, Town, or Location of Baltimore				4c. County of Death NA			
Funeral Director		219-76-3697	Gex 1 □ M 2(X F	e (In yrs. lasi 53	t birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birtl (Month, Day 1-5-5		9. Birthp Cour Md	* *	
Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County Md. NA		ity, Town or Location Baltimore				10d. Inside City Limits ↑ Yes 2 □ No				
or 28e-	Direct	10e. Street and Number 1214 Pearl Leaf Court			10f. Zip Code 21202					10g. Citizen of What Country? USA		
or death w tems 23a	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?									
hours afte	d by F	1 Never Married 2 Married 1 Yes, Give Year or Dates:			1 ☐ Yes 2X No Specify:					Specify: Black 16b. Kind of Business/Industry		
illed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28e-f ehow ont, the Medical Executes founds the notified at	Completed	(Specify only highest g. Elementary/Secondary (0-12) 7th grade	caucation rade completed) College (1-4or t		(Give life. L	ent's usual occup kind of work done DO NOT use retire emaker	during most of work	ing		Home	oustry	
ed ta by	To Be Co	17. Father's Name (First, Middle, Last) Randolph Lewis					18. Mother's Name (First, Middle, Maiden Sumame) Mae Elizabeth Gillan Williams					
Maryla d 2 should th and Men it is marke traumatic	F	19a. Informant's Name/Relationship	(Type, Print)				t and Number or Run	al Route Numbe	r, City or To	own, State, Zip		
DSBILLIMOTE, INIA permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tra		Ronald Summervi 20a. Method of Disposition Burial 2 Cremation 3	☐Removal from State	cem	ce of Dispo netery, crem	sition (Name of natory or other pla	ice)	Date	20c. Locat	tion - City or To		
SARTIMOF permit, Pages Department of Importent: If It any injury or o		4 □ Donation 5 □ Other (Spec21. Signature of Funeral Service Lice	ify)	Mt.	22	el Cem. . Name and Addre	DAR TERRITOR	Baltin	nore,		1202	
n goesa		March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cay e on each line. Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death										
Physician /Medical	ı	shock, or heart failure. List one Immediate Cause (Final disease or condition resulting in death)		n- l	L09			Live			Onset and Death	
Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter linderlying		coh	0/1.	s some					35 years	
3 / bU, ate be executed hysician and the burial-transit	Examiner	Cause (Disease of injury that initiated events c. resulting in death) Last Due to (or as a consequence of):										
OX 68 / 600 certificate be e nding physician use as the buris	edical		d									
death death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown				□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year			
S, F.	by	Part II. Other significant conditions contributing to death but not resulting in the				3			I tobacco use contribute to the cause of death? Yes 2 \(\sum \) No 3 \(\) Probably 4 \(\) Unknown			
Tec	Completed								prior to completion of cause of death?			
VITAL I	Be Co	25. Was case referred to medical 26. Place of Death (Check only one)										
Phys r this	ို	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	□ Inpatient 2 □ ER/Outpatient 3 □ DOA Cther: 4 □ Nursing Home 5 □ Residence 6 ★Other (Specify) 1650 € C € ate of Injury fonth, Day Year) 28b. Time of Injury at Work? M 1 □ Yes 2 □ No								
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of in	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route In City or Town, State)						al Route Number,		
To the Hospitel within 24 hours a To the Funerel I completely filled	edical C											
To the within To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo 29d. D						-				
D		30. Name and address of person wh	o completed cause of	death (Item 2		Print)	1428		11/	6/0	7	
Ü	ate		Stand 12. Regist	rar's Signatu		00	Joseph	Riche	y 1te	spece .	Baltimore	
Regis		31. Date filed (Month Day Year)	Bener			sports	i ·					

22:30 PM.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Physician 11:15 a.M. artos 200 OV /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number Examiner satimore Nalder If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 1 M 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director 7 is marked other than "natural", or Itame 23a or 28a-f traumatic evant, the Medical Examinar must be notifis 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U,S Armed Forces? Black, White, etc filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 PNo Specify: altimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Neme (First, Middle, 18. Mather's Name (First, Middle, Maiden Sumame) end Mantal Horatio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Wald of Health 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State ō 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) CoagolopaMi /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) and AIDS Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☑ No Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification: To 1 Yes 2 No 5 KResidence 6 ☐ Other (Specify) this eral Diractor: After thi filled in by the funeral 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 2 No within 24 hours after death. To the Funeral Diractor: Al 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 12, 2004

State Registrar

DHMH 16 Rev 6/95

2004

31. Date filed

4000 32, Registrar's Signature

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

D50736

203

Pikesville

MD 21208

Old

Registra

			For State Registrar	State of M	Marylan		artment of H		d Mental Hy	giene Reg. Ne	2001	35	863
	Physicia	an	1. Decedent's Name (First, Middle		.]				2. Date of D		Year	3. Time	of Death
	/Medic	al	Deanna 4a. Facility Name (If not institution,	Wooday		- woits	4b. City, Town, or	Location of D		40	County of Deal		1 77
Е	Examin	er	of Maryland Med			ersity		timore					
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. I		If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi Min. (Month, D	irth ay, Year,	9. Birt	hplace (State	or Foreign
П	Director		196-34-1499	1 □ M 2 💢 F	61	Yrs.			10/03/			nsylva	nia
	and and		Usual Residence of Decedent 10a. State 10b. County	-	10c. City	y, Town or Lo	cation					10d. Inside	City Limits
	Mary I-f sh	tor	Maryland		1	Baltim	ore					1 (X) Ye	es 2 No
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural" or Itams 23a or 28a-f show imatic event, the Medical Examinar must be notified at	Directo	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Co	untry?	
	238 c		736 West Vine S				2120			U.S			
	er dez Itams	Funeral	11. Marital Status	12. Was Decede	s?	.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin In, Mexican, P	? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ame Black, Whit		
36	Ir, or	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2 If Yes, Give Year or Date			I□Yes 2□XNo	Specify:			Specify: B1	ack	
Maryland 21215-0036	2 hou	ted	15. Decedent (Specify only highes	's Education		16a. Dece	ient's Usual Occup	ation	f working	16b. k	Kind of Business	Industry	
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Ž	2 should and Men is marka aumatic	ပ	William White 19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	g Address (Street		or Rural Route Numb	ber, City	or Town, State, a	Zip Code) 2	1201
<i>®</i>	1 and 2 : Health ar tam 27 is		Theartis Woodard	d / Husband	l				, Apt. A,				
Ze,	of Hei		20a. Method of Disposition 1 → Burial 2 → Cremation	2 Pomoval from Sta		lace of Dispo emetery, crer	sition (Name of natory or other plac	:e)	Date	20c. L	ocation - City or	Town, State	
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Balt	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e ODG.		21. Signature of Funeral Service	icensee		1			e Derrick ve., Balt				
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death	h. Do not ent				arrest,		Approxim Interval B Onset an	Between
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		d									
မှ	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcor	ne of pregna	ancy					23d. Date of del	ivery	
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	es tha igned be de	by P	Part II. Other significant condition	ons contributing to deat	h but not res	ulting in the u	nderlying cause giv	en in Part I.			use contribute to		of death?
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a H	iician: The lav certificate has rector, page 2								1 ☐ Yes	2 2 N		2 No	
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Division of Vital Records,	l or Attane after deatl Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad 280, Place of	Injury - At ho etc. (Specify	ome, farm, str	eet, factory, office		28f. Location City or To	(Street a. own, Stat	nd Number or Ru e)	ıral Route Nı	ımber,
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	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page	Medical		Exeminer: On the basis	s of examina								3(s)
	To the h within 2 To the f complete	Me	29b. Signature and title of certifier	r			29c. Licens	e number		29d. Da	ate signed (Mont	h, Day, Year,)
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,	\		30. Name and address of person	1 0	/	A A	Print)	225	Groono C+	R.	Lange	MTD 2	1701
	Sta		31. Date filed (Month, Day, Year)		Maryla istrar's Signa		lon.	de!	s GreeneSt	• 120	MINORE	1414 7	1001
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State of Maryland / Department of Health and Mental Hygiepe () 35864 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month GOO A M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kandalstuwn If Under 1 Year | If Under 24 Hrs. Battimore orinadell Social Security Number Date of Birth (Month, Day, Y 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 52-460 1 M 2 VF Yrs. Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or Items 23e or 28e-1 show treumatic event, It e Nedical Examinar must be notified at Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes_2 (DV)o If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 is marked other then "natural", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No BIACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-40/5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tre once. Date 20b. Place of Disposition (Name of cemetery, crematory or other pl 20a. Method of Disposition 20c. Cation - City or Town, State 1 Burial 2 Cremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) ghn C 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Greene Funeral She. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause up each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MAUCREATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Enter Lincolny, Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit that initiated events death certificate be exec resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 lo 1 Inpatient 2 ER/Outpatient ome 5 esidence 6 Other (Specify)
28d. Describe how injury occurred 3□ DOA 4 Nursing Home 27. Manner of Death completely filled in by the funeral Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of After 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D18587 of death (Item 23a) (Type, Print) Boltmore MD 2 au 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Amend item#10b, PerFH, C83/, 11/12/04 TI State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Th Month Year **Physician** 7.30 PM 2004 IIVIAN tovember /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, BALTIMORE NORTHWEST HOSPITAL Birthplace (Stete or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 201 F 213-16-9020 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent, the Martical Expansion of the results. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ual Hygiene. sd other then "neturel", or Items 23e or 28e-1 ahow avent. the Medical Essanbur must be notified at 1. Yes 2 □ No Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Naval Academy Elementary/Secondary (0-12) Coflege (1-4or 5+) (UNKNOWN) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALLEN TRAVERS ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 04 CAROL RD. BALTIMOKE HU 21207 Date (INKNOW) 200. Location - City or Town, State (INKNOW) MARGARETW. SMITH (DAUGHTER 6 20b. Place of Disposition (Name of MN KNCM) cemetery, crematory or other place) 20a. Method of Disposition

1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BROWN JR. FUNERAL HOME 2146 N. FULTONAVE. BALTO. MO. 21217 21. Signature of Funeral Service Licenses Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner unaru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenza of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🕱 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐Unknown 1 ☐ Yes 2XINo 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 (No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after deal To the Funeral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (ftem 23a) (Type, Print) Kau 22. Registrar's Signature State

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Registrar

State Registrar

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Xuy

31. Date filed No.M. day, Read 004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McTighe Modstrars Signature

001280

luion Memorial

			For State Registrar	State of	of Marylan	id / Depa	artment rtificate	t of H	lealth a Death	and M	lental Hy	giene Reg. No.	004	358	67
	Dharist		1. Decedent's Name (First, Middle		1 .						2. Date of De Month	Day	Year	3. Time of	
	Physicia /Medic		CLORIN	Jean	ω	EBST	FL				Nev.	10	2004	4:59	Ам
	Examin	er	4a. Facility Name (If not institution						Location	of Death			County of Deat	h	
			Howard County G 5. Social Security Number	eneral Ho	spital 7. Age (In yrs.	(act highday)	CO If Under	lumk	Dia If Under	24 Hrs.	8 Date of Bi		Howard	nplace (State o	as Foreign
	Funeral Director		219 54 7 572	1 ☐ M 2 🎞 F	54	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Date 12		Co	hingtor	
	D		Usual Residence of Decedent								12475 12	., 100	70 17405.		
	within 72 hours after death with the Maryland ene. Then "natural", or Items 23a or 28a-f ehow Te Medical Examirer mast be notified at	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits 2⊠No
	Ba-f	Director	MD Howar	d	C	olumbi		0-4-				10= Chi-	11/h-1 C-		223110
	with ti	吉	10e. Street and Number	7			10f. Zip						en of What Co	•	
	eath	erai	5053 Durham Roa		edent Ever in U	S. 13		2104		igin? (Sp	ecify Yes or N		Inited :		
	r Item	Funeral	1 ☐ Never Married 2 🛣 Marri	Armed F ied 1 ☐ Yes	orces? 2 ⊒Mso	1					ecify Yes or No Rican, etc.)		Black, White		
8	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1 ☐ Yes 2	2 XNo	Specify:			8	Specify: W	hite	
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121	within han.	mp	Elementary/Secondary (0-12)	College	1-4or 5+)	1	<i>во мот u</i> s nistr		•	eiet:	ent	Нос	pital		
2	Hygie Hygie ther t		17. Father's Name (First, Middle,	Last)		Adill	IIISCI	aciv			e (First, Middle	-			
au	d be antal	To Be	Charles Barkhim								Clemen		,		
Maryland	shoul nd Mi marl	F	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City or	Town, State, 2	(ip Code)	
Ž	alth a alth a 27 ls		John D. Webster	/Husband_		5053	Durh	am F	Road V	West	Columb	ia, M	D 2104	4	
ore.	es 1 a of He of He fitem r othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 DRemoval from		Place of Disponentery, crei	sition (Nam matory or o	ne of ther plac	:е)		Date	20c. Loca	ation - City or	Town, State	
altimore,	Pag ment ant: I		`4 □Donation 5 □ Other (S		Co						15-2004			•	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene is proported; or Items 23 a cr 28a-f show fine propriate: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic evant, Ite Medical Examinar natal be notified at once.		21. Signature of Funeral Service	licensee	M0104						cy H. W Pike El				
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that, only one cause on	caused the deat each line.	h. Do not en	er the mode	e of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximat Interval Bet	tween
}	Physician		Immediate Cause (Final disease or condition	Al.	sife 9	Failu	14							Onset and	
	/Medical Examiner		resulting in death)		(or as a conseq			`	\		1 1	\		0. \	\
		-	Sequentially list conditions, if any, leading to immediate		ارد در در الراد (or as a conseq		a T	Gre	457	MI	tus ta	+1C.	+0	d wang	177
	d Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	<	,	ir an	4 6	0 1							
o,	execting and ital-tra	Еха	that initiated events resulting in death) Last	C. Due to	(or as a conseq				•		-				
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89	ntifica ing ph	Med	IF FEMALE:												
õ	ath ce ttendi or use	lan/I	23b. Was decedent pregnant	1 Live	itcome of pregna birth 2 ☐ Feta	Ideath 3	Ectopic pr		,			23	d. Date of deli Month	,	Year
P.O. Box	the a	by Physician/Med	in the past 12 months? 1 □ Yes 20 No 9 □ Unknown	4∐Preg 9⊟Unki	nant at time of d nown	leath 5	Other (sp	ecity)						,	
	that the od by detac	/ Ph	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying c	ause give	en in Part I	l.	23e. Did	tobacco use	e contribute to	the cause of c	death?
Records,	uires r sign lid be	d b	Animia	Thromb	ccyto	Pensa	1				1 🗆	Yes 2	(No 3□Pro	obably 4 🗀	Jnknown
000	s beer	Completed	Coagulopal	70 cx	liver.	Fails	7				24a. Was		24b. Were au	topsy findings	available
Re	The la te has	omp	Aspiration	PAtumo							auto perf	ormed?	death?	ompletion of c 2□ No	ause or
Division of Vital	lan: rtiffca stor, p	BeC	25. Was case referred to medica						26. Place	e of Death	n (Check only				
>	hysic his ce I direc	To	examiner? 1 □ Yes 2 No			ER/Outpatier		A Oth	er: 4□Nu	ursing Ho	me 5 Res	idence 6	□Other (Spec	cify)	
ח	Ing P	:uo	27. Manner of Death 1 Natural 5 ☐ Pendir		of Injury oth, Day Year)	28b. Time o Injury		8c. Injun Worl	k?		28d. Describe	how injury	occurred		
Sic	ttend death tor: / the f	Icat	2 Accident investi 3 Suicide 6 Could	not be 390 Blac	e of Injury - At h	ome farm st	M factors		Yes 2□		28f. Location	Street and	Number or Ru	ral Route Num	her
<u>≥</u>	lor A efter Direction by	Certification;	4 ☐ Homicide determ	build build	ling, etc. (Specif	(y)	cot, raciory	, omce				wn, State)		747 110010 17011	561,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			ng Physician: To th											
	n 24 h	Medicai		Examiner: On the											.)
	To the To the Comp	Σ	29b. Signature and title of certifie	1 P					e number	•		29d. Date	signed (Month	, Day, Year)	
	,		Jon X. Min	N WD			1	3	057	5		11-1	0-04		
,	h		30. Name and address of person							c) ,				
	17		31. Date filed (Month, Day, Year)		S With Registrar's Signa		J was a	Par	Kwa	10	olinb	all bi	3102	14	
	Sta Registr		J. Date med (month, Day, 1941)	32.) Januar a Gigiti	1	-		*						
		te.	NOV 1 2 70	114 24	Ask-Od	0	Lan	6							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes 35868 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 33 **Physician** ANN WILLIS /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore (7 Ti Under 1 Year | If Under 24 Hrs.) Maryland Tall breneral Birthplace (State or Foreign Country) (In yrs. last birthday) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2X F 15, 1963 MARYLAND Director 213-70-0334 41 Aug. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location or 28a-f show 10a. State 10b. County 1 ☑ Yes 2 ☐ No BALTIMORE MD Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code rai', or items 23a or Examiner must be U.S.A. 2012 ETTING ST. 21217 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiene.
ant: If item 27 ie marked other than "natural; or iten ury or other traumatic event, the Michael Examinate ury or other traumatic event, the Michael Examinate 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 XNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify. 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CASHIER BURLINGTON COAT FACTORY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ٩ JERRY WILLIS VERONICA BROOKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important: If item 27 is eny injury or other tratonce. VERONICA BROOKS/ MOTHER 2012 ETTING ST. BALTIMORE, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 11-13-2004 BALTIMORE , MD 4 □ Donation 5 □ Other (Specify) METRO CREMATORY 22. Name and Address of Facility
WILLIAM C. BROWN COMM. FUNERAL HOME
1206 W. North Ave. Balto, MD 21217 21. Signature of Funeral Service WILLIAM C. 1206 W. NO Ulasa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Eno Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 Yes Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2X No Other: 1 Yes 2 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending 5 Pendina 1 Naturai 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of exemination and/or investing time. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title, (Item 3a) (Type, Print) who completed cause 7a 31. Date filed (Month, Day, Y Registrar's Signature 2 2004 State Registrar

			For State Registrar	State of Maryland / I	Depar <i>Certi</i>	tment of He ificate of D	ealth and Neath		iene _{eg. No.} 2 (004	35869
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	VIMPLE				2. Date of Dear Month	Day,	Year 04	3. Time of Death 4:25 A
	Examir		4a. Facility Name mot institution, give s 519 SEVEN TRAILS 5. Social Security Number 6. Sex	DRIVE 7. Age (In yrs. last bit	rthday)	ABERDE If Under 1 Year Wonths Days		8. Date of Birth		RFORD	ace (State or Foreign
2	Director	_	219-38-6326 Usual Residence of Decedent 10a. State 10b. County	M 20XF 65	Yrs.		THOUS WITH	DEC 7	1938	VIR	GINIA Od. Inside City Limits 1 Yes 2 XNo
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural', or Itama 23a or 28a-f show any injury or other traumatic event, Ite Medical Exertical Mitmatice Iteminal and ODGE.	Direc	MARYLAND HARFORD 10e. Street and Number 519 SEVEN TRAILS 11. Marital Status		ABERI	DEEN 10f. Zip Code 2100 as Decedent of His			0g. Citizen of \U.S.		ry?
-0036	hours after de stural, or Itam	ed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates:	1 C	'es, specify Cuban Yes 2 No No No No No No No No No No	Specify:	Rican, etc.)	Blad	ck, White, e	rtc. K
d 21215-0036	filed within 72 Hygiene. other than "ne	e Completed by	(Specify only highest grade Elementary/Secondary (0-12) 12yrs 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. DC	nd of work done du NOT use retired) USELOR		king	JOB COR	E IN	VIRGINIA
Maryland	d 2 should be th and Mental ?7 Is marked to traumatic ever	ToB	JOHN ALLEN 19a. Informant's Name/Relationship (Type Anthony I. Wilmolo (Address (Street ar	nd Number or Ru				
Baltimore,	. Pages 1 and thealt the tant of Healt tant: If I tem 2 jury or other		Anthony L. Wimple/ 20a. Method of Disposition 1Xi Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify)	emoval from State 20b. Place o cemete COMMUN	of Disposit Try, crema	tory or other place, FUNERAL	нм 11-1	Date	20c. Location -	City or Tov	
Bal	permit Depar Impor any in		21. Sign we of Funeval Service License 23. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do	WM 32	Name and Address I C BROWN I S PHIL the mode of dying,	COMM FU ADELPHIA	BLVD, F	BERDEE	N, MÓ	
8760,	Physician Medical Examiner The private and point of the private and the priva	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that inditated events resulting in death) Last	Due to (or as a consequence	of):	CANCE	3/6			1.50	Onset and Death
P.O. Box 6	that the death certifined by the attending posterior as as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		ctopic pregnancy other (specify)			23d. Dai Mo	te of deliver	y Day Year
Division of Vital Records, P	aw requires is been sign 2 should be	Completed by Pl	Part II. Other significant conditions con	tributing to death but not resulting i	- 1		n in Part I.	1 ☐ Ye	os 2 □ No	3 Proba	bly 4 Unknown sy findings available pletion of cause of
Vital R	Physician: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	ospital:		Other		h (Check only on) No 1		MO No
sion of	ding Phys	Certification: To	1 Yes 2 X No 1112 27. Manner of Death 1 X Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injury a Work? M 1 \(\text{Ye}	at Nursing Ho	ome 5 Reside 28d. Describe ho	w injury occurr	ed	
Divi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	cal Certifl	4 Homicide determined 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At home, fa building, etc. (Specify) ician: To the best of my knowledgier: On the basis of examination ar	e, death o	ccurred at the time	, date and place,	28f. Location (Str. City or Town and due to the ca	, State) use(s) and ma	inner as sta	ted.
ł	To the H within 24 To the Fi complete	Medical	one)	and manner stated.		20c License	number	1 20	nd Data signa	1 (Month D	lov Vaari
	9	10.5	30. Name and address of person who core of the SHARMA 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a) MD 602 5 32. Registrar's Signature	(Type, Pri	(IT)	ピカオル	06 BEC	AIR	2 0	021014
	Sta Registi	te	NOV 1 2 200	14 Page M	1200	14 M D					

DHMH 17 Rev 1/2001

	For	State of Maryland	Department of H			71114	35870
	1. Decedent's Name (First, Middle, L	ast)	Certificate of L		Reg. 2. Date of Death	_	3. Time of Death
Physician /Medica	DODDY	D. Wil	LSON		Nov.	Day Yeer 5, 2004	9:30 M
Examine	4a. Facility Name (If not institution, gr	ve street and number) CHIE HOUSE	47	Location of Death	ļ	46. County of Death	1
Funeral	5. Social Security Number 6.	Sex 7. Age (In yrs. last		,,,,,	8. Date of Birth (Month, Day, Ye	9. Birth	pplace (State or Foreign
Director	429-84-4069 Usual Residence of Decedent	1×M 20F 57	Yrs.	Hours Will.	APR. 24,	1947 AK	KANSAS
yland	10a. State 10b. County	10c. City, Tr	own or Location				10d. Inside City Limits
after death with the Maryland or Hema 23a or 28a-f show	$MD \cdot M$	IA BAL	TIMORE			0.00	1 Yes 2 No
with th	10e. Street and Number	OTTH ALLE	10f. Zip Code	217	10g.	Citizen of What Cou	intry?
death	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba		cify Yes or No-	14. Race - Amer Black, White	
36 s affer r, or lit	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: 2	Ank
5-0036 72 hours atter natural; or its	15. Decedent's	Education 1	6a. Decedent's Usual Occupa (Give kind of work done of	ation	161	b. Kind of Business/I	ndustry
Vithin 7	15. Decedent's (Specify only highest g	College (1-4or 5+)	life. DO NOT use retired	ining most of working	7	DISABL	ED.
d 2 filed w Hygie other t		(t)	D; 54BL	18. Mother's Name	(First, Middle, Mai		
laryland 21215-003 2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural; aumatic event, It's Medical Exit	FRANK U	21LSON		ROSE	TTA BI	ARNS	
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re, M s 1 and 2 f Health item 27	20a. Method of Disposition	20b. Place	e of Disposition (Name of etery, crematory or other place	LING I	ate 200	c. Location - City or	own, State
Page nent or ury or ury or	1 ☐ Burial 2 Cremation 3 4 ☐ Donation 3 ☐ Other (Spec	Trientovaniionii otate	-V V EW CR	EM. 11-12	-04 E	BALTO.	MD.
Baltimo permit. Page Department of Important: If Important	21. Signature of Funeral Service luc	insee de la	22. Name and Addres	ss of Facility 2	829 HUS	05010 5	
, _ 23244	23a. Part1. Enter the disease of co shock, or heart failure. List only	nplications that caused the death. [Oo not enter the mode of dying	g, such as cardiac or	r respiratory arrest,	ORE, MI	Approximate
Physician	shock, or heart failure. List onl Immediate Cause (Final disease or condition	one cause on each line.	ver cance				Interval Between Onset and Death
/Medical Examiner	resulting in death)	Due to (or as a consequent					1011,00
<u> </u>	Sequentially list conditions, any, learning to immediate cause. Enter Underlying Cause (Disease or injury	b. Sua to (or as a consequent	se of):				
executed n and ial-transit	= triat iriitiated events	C.					
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X 687 Certificate dding physise as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d					
Box 68 Box 100	F FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea				23d. Date of deliv	very Day Year
O. Bo the death	1 Yes 2 No	4□Pregnant at time of death 9□ Unknown	5 ☐ Other (specify)			WOTE	Day Toal
	> Part II. Other significant conditions		, , ,	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord:	Acquired Immun	e deficiency sym	rome		1 ☐ Yes	2 No 3 Pro	
2 2 as as 6 0.	ACQUIZE IMMULA				24a. Was an autopsy performed	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
ルバトラン Vital Records, vician: The law requires to certificate has been signer rector, page 2 should be detailed.	25. Was case referred to medical			26. Place of Death	1 ☐ Yes 2		2 No
of Vita Physician: this certific	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Other	20	ne 5□Residenc	e 6 Other (Spec	ity) Hospice
ding Physical distributions of the state of	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	b. Time of 28c. Injury Work		8d. Describe how i	injury occurred	,
Division Division or Attending after death. Director: Afte	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of Injury - At home		2	28f. Location (Stree City or Town, S	at and Number or Rui	al Route Number,
Divinital or urs after ral Dirinital or led in 18 led in		building, etc. (Specify)					
Division of Vital R Division of Vital R To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	29a. Certifier Certifying F	Physician: To the best of my knowled aminer: On the basis of examination and manner stated.	dge, death occurred at the tim and/or investigation, in my op	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the IV within 2 Complet	S 20h Signature and title of certifier		29c. License	number	29d.	Date signed (Month)	Day, Year)
• \(\lambda\)	1 2780 NA		D	24170	1	Vovember	8,2004
M	30. Name and address of person with	o completed cause of death (Item 23 chey Haspice 83 8	(Type, Print)	t Rell	inore N	17 21201	
State	31. Date filed (Menyla Daya Year) 2	32. Registrar's Signature	& doork	· IDALTI	1		
Registra	14047.95	,)	1 July con				

		1	For State Registrar	State	of Mary	land / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>	eaith and iv D <i>eath</i>		eg. No.	35871
ì			Decedent's Name (First, Middle	, Last)	1	1	-		2. Date of Dea		3. Time of Death
	Physicia	_	EUGENIA	1	11/	15-6011	15		Month	Day	7 4 2:55 AM
,	/Medic	_	4a. Facility Name (If not institution		umber)	71 / 1/4	4b. City. Town, or	Location of Death		4c. County o	of Death
	Examin	er	i i	•		Dkray				Paltir	Morro
			Genesis Elder 5. Social Security Number	6. Sex		yrs. last birthday)		Parkville If Under 24 Hrs.	8. Date of Birth	Baltir	Birthplace (State or Foreign Country)
	Funeral			1 □ M 2 K F	7. Ago (#	91 Yrs.	Months Days	Hours Min.	(Month, Day		
	Director	-	216-16-3385 Usual Residence of Decedent			31			Aug 29	1913	Maryland
	pur *	-	10a. State 10b. County		10	c. City, Town or Lo	cation				10d. Inside City Limits
	sho	5									1 ☐ Yes 2 No
	89-f	S S	MD Balti	more		Baltimor				I0g. Citizen of W	hat Country?
	ih th	Director	10e. Street and Number				10f. Zip Code			rog. Citizeri or VV	nat Country F
	th w	<u>_</u>	1801 Wentworth	Road			21234			United	
	dea	Funeral	11. Marital Status	12. Was De	cedent Eve Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- American Indian, c, White, etc.
٥	or It		1 □ Never Married 2 □ Marr	ed 1 Tes	2 X No		1 ☐ Yes 2 No	Specify:		Specify:	
9500-61212	rel',	5	3 Widowed 4 ☐ Divorced	Year or	Dates:						White
7	within 72 hours after death with the Maryland ene. than "naturel", or llems 23a or 28e-f show the Medical Ever in arrival be notified at	Completed by	15. Decedent (Specify only highes	's Education	d)	(Give	dent's Usual Occupa kind of work done of	furing most of work	ring	16b. Kind of Bus	siness/Industry
	hin and	pd	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT use retired)		Automob	ile
7	d wil	0	12			Cler	k Typist				
	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel" or liems 23a or 28e-f show the marked other than "naturel" or liems 23a or 28e-f show the market or cliffed at	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame	a)
a	ould be f Mental I Marked of Metic eve	To B	Nicholas C. Ma	nos				Emma He	enneuse		
Maryland	should Men		19a. Informant's Name/Relations			19b. Maili	ng Address (Street	and Number or Rui	al Route Numbe	r, City or Town, S	State, Zip Code)
<u> </u>	s 1 and 2 should f Health and Men item 27 Is marke other treumetic		Robert Watkins	/Son		6503	Sefton A	venue. Ba	altimore	- MD 212	214
	as 1 and 2 of Health litem 27 l		20a. Method of Disposition	7.5011			osition (Name of matory or other place		Date		City or Town, State
ō	Pages nent of I nnt: If its ury or o		1 Burial 2 Cremation		m State			*	Nov 12	D 71 11	1.1
	mer ment jury		* 4 □Donation * 5 □ Other (S				ake Crem <u>a</u>		2004	Beltsvi	ile, MD
Baltimore,	permit. Pages Department of Importent: If i any injury or o		21. Signature of Funeral Service	Licensee // /	MOR	09860	2. Name and Address Cremation	and Fun	eral Alt	ernativ	es
<u></u>	<u>ಸ೦೯ ಕ ನ</u>		2 HW	ul_			8717 Gree	en Pastur	es Drive	e Balti	more, MD
		1	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause or	it caused the n each lin <i>e</i> .	e death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ari	rest,	Approximate Interval Between Onset and Death
>	Physician		Immediate Cause (Final disease or condition	7	10'	iriun					2
	/Medical		resulting in death)	a	to (or as a c	onsequ <i>e</i> nce of):			*		(,)
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Ļ		er	Sequentially list conditions, if any, leading to initiodiate	Due 1	tù (ùr as a c	onsaquenea ut):					
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87	phys phys lhe	edical		0.							
	eath certifi attending I for use as		IF FEMALE:	23c. If yes,	outcome of	pregnancy				23d. Date	e of delivery
Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Liv		Fetal death 3	Ectopic pregnancy Other (specify)	,		Mon	
-	e de the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Un		ie di deatii Si	Other (specify)				
о. О.	at th	된	Part II. Other significant conditi		- doodb bud a	est seculting in the	radachina anusa an	on in Bart I	23e Did to	nbacco usa contri	ibute to the cause of death?
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5	w require been si			12,	1.24	oct lat	Zi i i we i)		62 5 140	ощи повион
S	s be	Completed	15 NEI	ntce					24a. Was autop	an 24b. W	Vere autopsy findings available rior to completion of cause of
æ	he la e ha	E							perfo	rmed? d	eath? ☐ Yes 2 KNo
Division of Vital Records,	n: T fficat or, pë	Ö	25. Was case referred to medica					26. Place of Dea			
5	Physicien: r this certificanal director, I	00	examiner?	Hospital	☐ Inpatient	2 ☐ ER/Outpatie	ent 3 DOA Oth			lence 6 Othe	er (Specify)
ō	Phys this at di	ို	1 Yes 2 No 27. Manner of Death		te of Injury	28b. Time	of 28c. Injur	v at		ow injury occurre	
Ë	ing After uner	lon	1 Natural 5 Pendi	ng (M	fonth, Day Y		Wor	k? Yes 2∐No			
<u>S</u>	Attending it death. ector: After by the fune	cat	2 Accident investi		f faire	. At home form			28f Location /	Street and Numbe	er or Rural Route Number,
≥	or At offer d Direct in by	Certification;	4 Homicide determ	ined 288. Pi	ilding, etc. (- At home, farm, s (Specify)	neer, ractory, office		City or Tox		57 57 7167 2 1 716216 715115
	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2										
	losp L hou une	cai	29a. Certifier 1 Certifyi	ng Physician: To Examiner: On the	the best of a	my knowledge, dea kamination and/or i	th occurred at the time time time.	me, date and place opinion, death occu	, and due to the or rred at the time,	cause(s) and m <i>a</i> r date and place, a	nner as stated. and due to the cause(s)
	the H in 24 the F plete	Medical	one)	and m	anner state						
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Σ	29b. Signature and title of certific		250	werlan S	29c. Licens				(Month, Day, Year)
			K -		- 10	CE INTO		2011/10	1	11,	1012004
			30. Name and address of person	who completed c	ause of dea	th (Item 23a) (Type	, Print)) \ A	0.	2 1 10	Dell Lana Wa
	1.		30. Name and address of person	W WAT	w,	16. El CA	M/6,20,	2, 100%	raven	12116	1 ECCINALATE WAY
	St	ate			Registrar's	s Signature	1				
	Regist		NOV 1 2 2	2004	2 reas	B	Sports	/			
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			1 - For State Registrar	State of M	arylan		artmen			ınd M	Re	g. No.		35872
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Las MILD) 4a. Facility Name (If not institution, give	RED , I		LERY		Town, or	Location o		2. Date of Deat Month November	Day	Year 2004	3. Time of Death 3.42 A M
	Funeral Director	eı	HARBOR HO 5. Social Security Number 6. S	SPITAL C	CENT	ER ast birthday) Yrs.	If Under Months		BAL- If Under:	Min.	8. Date of Birth (Month, Bay, Dec. 9,		N/A 9. Birt	hplace (State or Foreign unity)
	D	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A			, Town or Lo							o Pei	nnsylvania 10d. Inside City Limits 1 X Yes 2 No
	ath with the \$ 23a or 28 wat be no	rai Director	10e. Street and Number 4926 Pennington				10f. Zip	2122				U	on of What Co	
900	72 hours atter death with the Maryland naturel', or items 23a or 28a-1 show deal Examinar rust be notified at	d by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 🏋 Widowed 4 □ Divorced	12. Was Decedent Armed Forces: 1 Yes 2 X If Yes, Give Year or Dates:	?	'	Was Deced f Yes, spec 1 ☐ Yes 2			jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		. Race - Ame Black, White pecify: Wh	
21215-0036	tiled within 72 h Hygiene. other than "nati	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 11th		5+)		dent's Usua kind of wor DO NOT us tory	k done d e retired)	uring most	of workin	ng		of Business/	
Maryland	should be till ind Mental H s marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) Joseph 19a. Informant's Name/Relationship (1)	Harold Mo	rriso		na Addrass			Dais	(First, Middle, May Mae G	i1pi	n	To Code
	es 1 and 2 of Health a f item 27 ls r other tre		James Simkins J 20a. Method of Disposition 1 🕮 Burial 2 🗆 Cremation 3	r. /Grand	20b. P	2525 lace of Dispo	Blue sition (Narr natory or of	Wate	er Blv	∕d.	Odent	on,	Maryla ition - City or	nd 21113
Baltimore,	permit. Pag Department Importent: It any injury o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		ush	1 22		d Address	s of Facility	Gor	nce Fune	era1	Servic	
	Physician /Medical		23a. Part1. Enter the disease of comp shock, or heart failure List only Immediate Cause (Final disease or condition resulting in death)	one cause on each I	CUTE	My	or the mode				respiratory arre	st,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		REATI a consequ	ON OF Jence of):	CHRI	069 I E	OBST	RUCT	IVE LUNG	Dist	FAS€	7 DAYS
.O. Box 6	death certif e attending od for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pre					230	d. Date of deli	very Day Year
s, P	The law requires that the tite has been signed by thoage 2 should be detache	by	Part II. Other significant conditions o	ontributing to death b	out not resu	ilting in the ui	nderlying ca	luse give	n in Part I.					the cause of death?
Vital Record		Completed	RIAHT LU	VC NODE	LAR	MASS					24a. Was an autopsy perform	ed?		topsy findings available ompletion of cause of
of	Attending Physicien: Thr death. sctor: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	Jry VIL	ER/Outpation 28b. Time of Injury		Bc. Injury Work	r: 4 🗆 Nur	sing Hom	(Check only one to the S Resider 8d. Describe how	nce 6		ify)
Division	P = E	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At ho tc. <i>(Specif</i> y		eet, factory	office		2	8f. Location (Str. City or Town,	eet and N State)	Number or Ru	ral Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely tilled it	edicai	one)	ysician: To the best liner: On the basis o and manner st	ot examinat	wledge, death ion and/or inv	estigation,	in my op	inion, deat	l place, ar h occurre	d at the time, da	te and pla	ace, and due	to the cause(s)
•	To To con	Σ	29b. Signature and title of certifier NV Shambhay (R				٤)	License R E		01		d. Date s D∨€M	signed (Month	. Day, Year)
			30. Name and address of person who is NITA SHANGHAC, MD (1) 31. Date filed (Month, Day, Year)	CY IN RESIDEA	IT IN N	EDICINE	Print)) , HAR	BORH	Ti 120+	al ,3	ocol Scutt	H HAM	MOVER S	TREET, MD - 21225
•	Sta Registi		NOV 1 2 200	4 Kiran	rar's Signat	C Son	ME							

State of Maryland / Department of Health and Mental Hygienes For Stata Registra 35873 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** 11/05/2004° DOROTHY WIENHOLD 10:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ocean City 8800 Coastel Hwy. Sea Terrace #506 Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 1 M 2 F 84 Director 215 09 8391 1920 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Eventral must be notified at 1 ☐ Yes 2 No Director Maryland Worcester Ocean City 10e. Street and Number 10f. Zip Code #506 10g. Citizen of What Country? 8800 Coastel Highway Sea Terrace 21842 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2M No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personnel State of Maryland 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental F int: If item 27 Is marked of Edward Martin Gunning Mary Catherine Dukert ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Katherine DeGrange 416 Joyce Drive SW Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ RemovaNtrom State Holy Cross Cemetery 11/9/2004 ' 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee ponce 4001 Ritchie Highway Baltimore, Maryland 21225 eart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STOME disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed and that initiated events resulting in death) Last burial-t Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached fi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 21 No 1 Yes director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation Hospital or Attending 1 Natural Injury n 24 hours after deam. death. 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Joseph McShea 10514 Racetrack Road Unit C Berlin, Maryland 21811

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year,

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35874 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Robert Orville Wright 11:10 A^M November 2004 6 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sunrise Assisted Living Severna Park Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 25, 1 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 162 26 4685 Yrs 1933 Director Maryland Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10d. Inside City Limits the Medical Examination but be notified at 1 Yes 2X No Maryland Linthicum Director Anne Arundel 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21090 704 West Maple Road U.S. or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 150 Yes 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status e filed within 72 hours after di al Hygiene. i othar than "natural", or Itam Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Westinghouse permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Itam 27 Ia marked othar this any Injury or other traumarth 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Berlin Wright Sr. Nellie Flaharty ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Hymers / Daughter 704 West Maple Road Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem 11/10/2004 Crownsville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2-5 4ear Immediate Cause (Final disease or condition resulting in death) A 3 heim ers

Due to (of as a consequence of): 15ease Physician Years /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events anding physician and use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the atten If be detached for u 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Living 2 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3☐ DOA 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? of or Attanding Patter death. Certification: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel o within 24 hours at To the Funeral D completely filled in 1 🕑 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) man mother D0023861 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie, MD. 21061 Dr. Jonathan Forman 1406 B. South Crain Highway #304 31. Date filed (Month, Day, Year) NOV 1 2 2004 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 200435875 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:45 PM Emily Beury Widmann November 9 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Pickersgill Retirement Community If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Foundation) April 30, 5. Social Security Number 7. Age (In yrs. last birthday) 85 Yrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 💢 F 137-14-3221 1919 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 27 is markad othar than "natural", or Items 23a or 28a-f show traumatic event. The Modical Examiner must be mutified at 1 ☐ Yes 2 No Towson Be Completed by Funeral Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? United States 21204 615 Chestnut Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Winifred Faust James Beury 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Baltimore, MD 369-2B Homeland Southway itam 27 Nancy Matthews/niece injury or other Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Greenmount crematory Nov. 11,2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Mitchell-Wiedefeld Funeral Home. Inc. 6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee when o Approximate Interval Between Onset and Death 23. Pr.11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final cars Physician resulting in death) /Medical Due to for as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, sense-1 ☐ Yes 2 No 3 Probably 4 Unknown brillata 24a. Was an TAL 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. the Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time. within 24 hours a 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier in I 5 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) N. Chn Balto Md 6701 32. Registrar's Signature State Registra

State of Maryland / Department of Health and Mental Hygieney 35876 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jerome C. Wilkerson /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner ltimore General None If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days DOM 20F 48 1956 Director dct. 217-62-8360 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 No Maryland Prince George's Forestville Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 6602 Nyack Place 20747 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Department of Health end Mental Hygiene. Important: If item 27 is marked other than "I eny injury or other treumatic event, the Max Quee. than Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Mechanic Quality Auto Repair 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles G. Wilkerson Annette R. Simms 2 19a. Informant's Name/Relationship (Type, (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Simms Annette R. Wilkerson 6602 Nyack Place Forestville, Md. 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 11/8/04 Moses Cemetery Drury, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Zarry J. Rees: Mo 483 Wm. Reese & Sons Mortuary 821 West St. Annapolis, M 821 West St. Annapolis, M shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meymocus **Physician** Due to (or as a consequence of): /Medical **Examiner** seudomona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only Totale 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) - a and add ess of person who completed cause of death (Item - a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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/Medica		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location	of Death		4c. County of Death	
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Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (:	3 □Removal from Sta Specify)	ate Ba	Place of Dispo cemetery, crer yview	natory or o Crema	ther place tory	⁹⁾ N	lov. 5 2004		20c. Locatio Baltir		
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eco	e law requir has been si je 2 should t	Completed	Hyperte.	nsion							24a. Was a		o. Were auto	psy findings available mpletion of cause of
E B		Соп	0'								perfor	med? 2000	death?	2□ No
Vit.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	n		(Check only or		A:	esisted
of		n: To	1 Yes 2 To	28a. Date of	njury	28b. Time of		8c. Injury Work	4 🗆 Nu		ne 5 🗌 Resid 28d. Describe h		ther (Specif urred	nuving
ion	Attending I or death. actor: After by the funer	atlo	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ing (Month, tigation	Day Year)	Injury	м		? ′es 2 □1	No				
Division	after death after death Diractor:	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 288. Place of	Injury - At h , etc. <i>(Speci</i>	ome, farm, str	eet, factory	, office		2	28f. Location (S City or Tow		nber or Rura	I Route Number,
	To the Hospital or Attuwithin 24 hours after de To the Funeral Diracto completely filled in by the	edical C	29a. Certifier 1 Certifyi (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basi and mannel	s of examina	owledge, death ation and/or inv	occurred avestigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the co	cause(s) and r date and place	manner as s e, and due to	tated. the cause(s)
.	To th withir To th comp	Me	29b. Signature and title of certific			IMA	290	. License	number	72	5	29d. Date sign	ned (Month,	Day, Year)
			30. Name and address of persor	who completed cause	of death (Iter	m 23a) (Type,	Print)	U	11		11-11	- /		MD 21108
	Sta	te.	31. Date filed (Month, Day, Year	Xiedincer 22. Re	Strar's Signa	5601	12101	rans	Hu	vy	1º11 Ve	rsv.C	les	MD 21108
	Registr		31. Date filed (Month, Day, Year	1 2 2004	here	# 1	Swell .	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend tate of Maryland? Departmens 837 eath and Mental Hygieze O L 35880 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** John Edwards Allen 11<u>,</u> 7 Od AM 2004 Nov. /Medic 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson TOWS OIL

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | July 22, Gilchrist Center 5. Social Security Number 9. Birthplace (State or Foreign 1942 Jamaica, WI 7. Age (In yrs. last birthday) **Funeral** Year) 216-55-8326 **1** 2□ F 62 Director Yrs. Usuel Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Exprange must be multilad at Baltimore N/AMaryland 1X Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 5308 Nelson Avenue Jamaica death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 sBl_wack 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Factory Worker 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Majden Sumame) Leoline McKenzie Thomas Allen 19a. Informant's Name/Relationship (Type, Print)
Valerie Allem Sister-inAllen Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code) 5308 Nelson Ave Baltimore, Maryland 21215 Department of Health a Important: If Item 27 is any injury or other tra once. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 11-/20/04Blackness District 1

Burial 2 □ Cremation 3 □ Removal from State Family Plot `4 ☐ Donation 5 ☐ Other (Specify) Westmoreland, Jamaica 22. Name and Address of Facility Chatman Harris Funeral 2 Home 5240 Reisterstown Rd Baltimore, Md 2 1215 21. Signature of Funeral Service License6 Werer ken 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 9/106/astoma **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-tran Due to (or as a consequence of): attending physicien for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dother (Specify) NOSPICE 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: death. within 2

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) Nevember 11 2004

rance so Baltemor uno 20204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(AMPLUE) and

31. Date filed (Month, Day, Year) NOV 15 2004

4 | Homicide

(Check only one

29b. Signature and title of certifier

29a. Certifier

Medical

State

Registrar

32. Registrer's Signature

				Pleas	State of	of Marylar						-		egible.		
			1 - State Registrar					rtificat					Reg. No.2	004	3588	
	Physicia		Decedent's Name (F		Last)	R	Lo					2. Date of De.	ath Day	Year Zuo	3. Time of Death 2:45 p.M	ut
	/Medic Examin		4a. Facility Name (If no	t institution,	give street and nu	mber)	L C	4b. City,	Town, or	Location of	f Death	11	4c. C	ounty of Deat		_
			742	3 \	lillage	Road		Syke						rroll		
	Funeral Director		5. Social Security Number 100-20-920 Usuel Residence of De	1	S.Sex 1☐M 2∏XF	7. Age (In yrs.	. last birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Birt (Month, Da Apr 18	y, Year)	9. Birtl Co NY	nplace (State or Foreig untry)	m
	Maryland -f show	tor		b. County	roll		ty, Town or Lo Sykesvi								10d. Inside City Limits 1 XYes 2 No	
	a or 28a	I Direc	10e. Street and Numbe 7423 Vi		Road Ar	t 2		10f. Zip						n of What Co USA	untry?	_
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any njury or other traumatic event. The Medical Examination at a sufficient and once.	Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		Armed Fe	ve X No		Was Deced If Yes, spec		spanic Orion, Mexican Specify:	jin? (Spe , Puerto i	cify Yes or No Rican, etc.)	- 14	. Race - Ame Black, White pecify: wh:	e, etc.	
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Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If itam 27 is any njury or other tra once.		20a. Method of Disposi 1 ☐ Burial 2 ☐ C 1 ☐ Donation 5	remation 3 Other (Spe	ecity)	State	Place of Dispo cemetery, crer .1 Coun	ty Cr	ther place emat	ion 1	1-15		Sykes	tion · City or i	Md	
Bal	Departiment Important Indiana		21. Signature of Funer	. 9 .		ut	22 P	. Name an	d Addres	s of Facility 95 Sv	/ Hai	ght Fur ille, N	neral Md 217	Home &	& Chapel	
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I Records,	The faw requirate has been spage 2 should	Completed by	Nyper	lipid	emia								an 2 sy med? 2 100	death?	opsy findings available ompletion of cause of	3
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of	는 부르	atlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident	☐ Pending investiga	28a. Date (Mon		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 🗆 1401	2	ne 5 Resid 8d. Describe h			ífy)	
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	Sta	à	30. Name address 2 N J O.W 31. Date filed (Month, L	nin t	Papoi I	se of death (Iter	108	C L	isbo	n Cen	der	Drive	Woo	Obine	MD 2179-	7
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Registrar

			For State Registrar	State of Ma	aryland				ealth a Death			gienę.	71111	4 35883
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,	/Medic Examin		4a. Facility Name (If not institution, give					Town, or	Localion of	of Death			County of	2.30 1
	LXMIIII	CI	Suburban Hospin	tal					hesda				Mont	tgomery
	Funeral		Social Security Number 6. Sex			ast birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs.	8. Date of Birt (Month, Da	th v. Year)		Birthplace (State or Foreign Country)
	Director		340-12-3773	[M 5 F	82	Yrs.		Jujo	110010		July 1	12,19	22	Austria
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary of sh	ţō	Maryland Montgor	nery				Beth	esda					1 X Yes 2 ☐ No
	th the	Director	10e. Street and Number				10f. Zip	p Code				10g. Citiz	zen of Wha	ut Country?
	23a c	ralD	5011 Elm St.						2081	.4		Un	ited	States
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ā,	of Health itam 27 other tr		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Na	me of	a)	Da	ite	20c. Loc	cation - Cit	y or Town, State
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Baltimor	permit. Pages Department of I Important: if its any injury or o once.		21. Signalure of Funeral Services License	nam		22	Name ar Rapp 933	Fund Gist	s of Facilit eral Ave.	and C	Cremati ver Sp	on S	ervic	ces 20910
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused te cause on each lin	I the death. ne.	Do not ente	er the mod	de of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	. I1	ntrac	ranial	l Hem	orrh	age					Onset and Death 3 days
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Ś	w requires that the bean signed by should be detac	ру Р	Part II. Other significant conditions con	tributing to death bu	ut not resul	ting in the ur	nderlying o	ause give	n in Part I.		23e. Did to	bacco us	se contribu	te to the cause of death?
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0	g Phy er this eral c	-	27. Manner of Death	28a. Dale of Injur (Month, Day	гу :	28b. Time of		28c. Injury Work			d. Describe h			specity)
0	andin sath. or: Aft he fur	atio	1 Natural 5 Pending investigation	(Month, Day	/ 1 6a1)	Injury	М		es 2 🗆 N	No				
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	12		30. Name and address of person who co								4.1. 1	3.00	000	117
	Sta	to	Joanna Wei-Chin I	Ku M.D.; 32. Registra			Geor	getor	wn Kd	., Be	thesda	, MD	208	014
	Registr		NOV 1 5 2004	Green			1	1.						

		State Registrar 1. Decedent's Name (First, Middle, L.)		aryland /		te of Death	2. Date of D	Rag. No	200	3. Time of Death
Physic		Jane M. Bart					Month	Da		
/Medi		4a. Facility Name (If not institution, gi			4b. City.	, Town, or Location of	of Death		County of Dea	
LXdIIII	ilei		OSP. tal Cent		Box	sedak		P	a Itimor	
Funeral		5. Social Security Nutaber 6.	Sex 7. Ag	e (In yrs. last b		r 1 Year If Under		lirth	Q Ri	rtholage (State or Fore
Director		210-03-4304	1□M 2 X F	87	Yrs.	Days	01727	7191	7 Ma	ryland
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Location					10d. Inside City Limi
Mary	ō	Maryland N/	A	Balti	imore C	itv				1 ∀ Yes 2 □ 1
death with the Maryland ms 23a or 28a-f show LITMEL to notified at	rec	10e. Street and Number				p Code		10g. Ci	tizen of What C	Country?
h witi	a D	412 South Ann	Street		2	1231		Uni	ited St	tates
INE, MATYIANG ZIZID-UU30 Is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Existing Inter Intelligial at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dece	edent of Hispanic Ori	gin? (Specify Yes or N , Puerto Rican, etc.)	10-	14. Race - Am Black, Whi	
s after	y Fu	1 Never Married 2 Married	1 Tes 2		1 ☐ Yes		, , , , , , , , , , , , , , , , , , , ,		C#	
5-UU30 72 hours after natural; or its	d by	3 Widowed 4 □ Divorced	Year or Dates:	166	2 Decedent's Hea	ol Oscupation		100	VV 1	hite
on 72	olete	15. Decedent's E (Specify only highest g	rade completed)		(Give kind of wo	ial Occupation ork done during mosi ise retired)	t of working	16D. K	Kind of Business	s/industry
Z1Z15-UU36 d within 72 hours aft giene. er than "natural", or the Medical Exam	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+) I	Homemak	er		Do	omestic	C
nd Z	Se C	17. Father's Name (First, Middle, Las	st)			18. Mothe	r's Name (First, Middl	e, Maider	n Sumame)	
should be nd Mental t marked oumatic even	To Be	Stefan Czyz				Jos	ephine G	azdo	wicz	
Saltimore, Maryland semit. Pages 1 and 2 should be fit begarmen of Health and Mental Hymporant: If item 27 is marked oth my nigury or other traumatic even page.		19a. Informant's Name/Relationship	. ,, .		•		or or Rural Route Num.			
and and m 27	П	Patricia Prich	hard-Daug							
Pages 1 Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 (☐Removal from State	cemete	of Disposition (Na. ery, crematory or o	other place)	Date		ocation - City or	
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bait permit. Depart import any inj		21. Signature of Funeral Service	nsee 3	1	Dayid	nd Address of Facilit J., Webe	r Funera ster Str	1 Hc	mes.P.	. A .
		23a. Part1. Enter the disease, or or	molications that caused	the death Do					Baltin	nore, MD21
		shock, or heart failure. List ont	y one cause on each li	ne.	THOU SHIELD WIS THOU	oe or dying, sacir as	carciac or respiratory	arrest,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a 5 radyc	ardie Ar	rest					
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	e									
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8 / 6U, sate be execu physician and the burial-trai	<u>a</u>	Sequentially list conditions, I any leading to arrive additional acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as							
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ORIGINAL

			For State Registrar		State	e of Ma	arylan		artment of rtificate o				giene ,	711111.	35885
	Physicia		1, Decedent's Name	First, Middle		er Jo	seph	Brewe	r		1	2. Date of De Month		Year	3. Time of Death
	/Medic Examin		4a. Facility Name (fi							, or Location o	of Death		4c. C	County of Death	10/1
	Funeral Director		Atlantic 5. Social Security N 215-22-1	umber	6. Sex 126 M 2	7. Age	e (In yrs. i	ast birthday, Yrs.	Berl If Under 1 Ye Months Day	ar If Under	Min.	B. Date of Birt (Month, Da	h y, Year)		place (State or Foreign ntry)
	death with the Maryland rme 23a or 28a-f show r cust be natified at	ctor	Usual Residence of 10a. State Maryland	10b. County	rcester		10c. City	y, Town or L	ocation	Berlin	1				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the	rai Director	10e. Street and Nun 7 Bay Vi						10f, Zip Cod	21811			Uni	en of What Cour ted Sta	tes
980	72 hours after death with the Marylan *natural*, or Itame 23a or 28a-1 show rdical Examiner must be malified at	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ied 1-5-14	Decedent I d Forces? es 2 N s, Give or Dates:	10	S. 13.	Was Decedent of the Yes, specify C		gin? (Spec i, Puerto Ri	ify Yes or No- ican, etc.)		4. Race - Americ Black, White, Specify: W	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mantal Hygiens. Important: I flem 23a or 28s-1 ehov important: I flem 27 is marked other then "natural", or Itame 23a or 28s-1 ehov eny injury or other traumatic event. The Madical Examiner count be multified an once.	Completed	(Spec Elementary/Secon 12 Years	ndary (0-12)	st grade comple.	<i>ted)</i> ge (1-4or 5	+)	(Give life.	dent's Usual Oci kind of work do DO NOT use ret	ne during most	t of working	7		of Business/In	
yland 2	ould be filed Mental Hyg arked othe atic event.	To Be C	17. Father's Name (First, Middle, Brewe	r						(Maiden S ine C	umame) ampbell	
e, Mar	1 and 2 shd Health and em 27 le m ther traum		19a. Informant's Na Mrs. Eliz 20a. Method of Disp	abeth				7 Ba	ng Address <i>(Stre</i> y Vista esition <i>(Name of</i>			lin, Ma	aryla		11
altimor	mit. Pages partment of a portant: If It y injury or o			☐ Cremation 5 ☐ Other (S		rom State	a	emetery, cre wnsvil 2	le V.A. Name and Ade	Cem. 11	L/15/2	2004	Cro	wnsvill	e, MD
8	Deparing Department of the partment	23a. Part1. Enter the shock, or hear	ne disease, or rt failure. List	complications the	hat caused on each lin	the death	7	ruda-Ruc 922 Wise ter the mode of d	e Ave.	Dund	lalk, M	lary1		222 Approximate Interval Between	
261	Pnysician /Medical Examiner	Examiner	Immediate Cause (disease or condition resulting in death) Sequentially list condition and list conditions are cause. Enter Under Cause (Disease or that initiated events	n	a b Due	e to (or as a	a consequal consequal	uence of):	2/7	wit.	İ				Onset and Death 3 days 50 years
2-96- 1-11-0 68760,	ificate be executed g physician and as the burial-transit	dical	resulting in death) L	Last	d.	e to (or as a	a consequ	uence of):							
7.0.18 1.	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Li 4 ☐ P	, outcome ive birth regnant at Inknown	2 🗌 Fetal	death 3	Ectopic pregnal Other (specify)				23	d. Date of delive Month	ery Day Year
er f	w requires that the been signed by th should be detache	þ	Part II. Other signifi	icant condition	ons contributing	to death bu	ut not resu	ulting in the u	nderlying cause	given in Part I.	_	23e. Did to			ne cause of death?
1/2/1 2-130 al Rec	The lavate has	Completed										24a. Was a autop perfor 1 Yes	med? 2 No	24b. Were autoprior to condeath?	psy findings available impletion of cause of
	Phys rthis raldii	ition: To Be	25. Was case referrexaminer? 1 Yes 2 2 27. Manne of Death 1 Natural 2 Accident	No	Hospital: 28a. D	1 Inpatie Date of Injur Month, Day		ER/Outpatier 28b. Time o Injury	f 28c. In	Other: 4 Nu	rsing Home	Check only of 5 ☐ Resid d. Describe h	ence 6[Other (Specify	1)
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 286. P				eet, factory, offic		28	City or Tow	n, State)		l Route Number,
:	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	Medical	29a. Certifier (Check only one) 29b. Signature and	2 Medical		the basis of manner sta	examinat	wiadga deat ion and/or in	vestigation, in m	y opinion, deat	d place, and h occurred	at the time, o	iate and pi	lace, and due to	the cause(s)
	¥ 8 4 8	-	30. Name and addre		IC (cause of	Ohe	5/4 23a) (Type	Print)	4438	73		11/1	1/04	-u _f , , ou//
	Sta		Robe 31. Date filed (Mont	24.	DUK	32. Registra	97	3 /+	ec/The	vay !	Drin	x	B	erlen	MD
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Florian Vincent Boracki November 2004 10:00P M /Medical 13 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Eldercare Heritage Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 7 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2 □ F Director 220-14-6932 1924 Maryland Usual Residence of Decedent the Maryland 10a State 10b Count 10c. City, Town or Location 7 is markad othar than "natural", or itema 23a or 29a-f show traumatic event, <u>tra Medical Examinar must be notified at</u> 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1404 Dundalk Avnue 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1≿ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Pages 1 and 2 should be filed within Dep rument of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event Waste Water Treament College (1-4or 5+) NA Elementary/Secondary (0-12) 6 Maintenance Mechanic Plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Borscki Rosalie Knasiak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1404 Dundalk Avenue Baltimore, Maryland 21224 Eleanor Boracki (Wife) 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition November 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus 16,2004 Baltimore, Maryland W. Dabrowski/Chojnacki Funeral Homes P,A. 21. Signature of Fyheral S-N c Lic 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, son each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Secuer tielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit PTERIO-SCIEROTIC CARDIO MASCULAR DISEASE that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy lor in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DUCOR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: ို 1 Yes 2 VIO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Mursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral I Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year)

1041

State Registrar 31. Date filed (Month, Day, Year)

th, Day, Year)

38. Registrar's Signature

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ause of deputy (Item 33a) (Type Pfirit)

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	Physicia	an	1. Decedent's Nam	me (First, Middle, L				/ 42			2. Dete of Dee	eth	Year	3. Time of Death
	/Medic	cal	Jess 4a Facility Name ((If not institution, gi	Bax (ter			O'A. T		November			5:00 AM
	Examin	er	4a Facility Name (/ Long Green		ive street and no.	imber)			4b. City, To Baltim		ocation of Death		ounty of Deeth	
	Funeral		5. Social Security N	Number 6.	Sex	7. Age (In)	yrs. last birthday)		r If Under		8. Date of Bir			place (State or Foreign
	Director		218 - 28 - Usuel Residence of	-8424	1□M 21XPF		72 Yrs.	Months	Nous	Mar.	8. Date of Birth (Month, Day June 3,	1932	South	place (State or Foreign Intry) Carolina
	wor.	1	Usuel Residence of 10a. Stete	of Decedent 10b. County		10c.	c. City, Town or Lo	ocation					-	10d. Inside City Limits
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121	within ene.	Completed	Elementary/Secon			(1-4or 5+)		DO NOT use retired Housewife	d)	1 6.	•		Domestic	1
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ylar	2 should be f end Mental F is merked of aumetic ever	ToB	Robert Part						1.		Cauley			
Mar	td 2 sho Ith end I 7 is me		1	Name/Relationship				ing Address (Street				-	own, State, Zip	Code)
Baltimore, Maryland 21215-0036	es 1 end 2 of Health I Item 27 i	1	20a. Method of Disp	. Smith/So			b. Place of Dispo	343 N. Carey osition (Name of		t. Das			tion - City or Tox	own. State
OE .	nit. Peges ertmant of I ortant: If ite injury or o		1 Burial 2	☐ Cremation 3 ☐ 5 ☐ Other (Special			cemetery, cien Mt. Zion Ce	ematory or other plac Cemetery	ce)	1.	1-13-04		sdowne. M	
3alti	permit. Pege Depertmant of important: If any injury or pnce.		21. Signature of Eur	Feral Service Lice	ansee /	1	22	2. Name and Addres		lity				
7	20 E a a		1/11	m/n/11	1/1/1/	/=		Wylie Funera					Balto, M	1D 21217
	Physician /Medical Examiner		Immediate Ceuse (I disease or condition resulting in deeth)	(Final		Panc	^		ince					Approximate Interval Between Onset and Death
	flicate ba g physicia es the bur	o	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i that initieted events resulting in death) L	S	c		o (or es e consequ							
Box	Jeath c e etten 3d for u	Physician/M	Pert II. Other signific	ficent conditions	contributing to d	teath hut not	resulting in the V	- terbina cause gir	in Part I		23h Didt		ibute (c	the cause of death?
s, P.O.	law requiras thet tha death certif as been signed by the ettending 2 2 should be detached for use e	by Phys		ment conditions o		CVP	asuming	TW ((A)	4		obacco use o		o the cause of death? bably 4 ☐ Unknown
Division of Vital Records,	e law requiras the has been signed ge 2 should be del	Completed I								_	24a. Was ar perforn		avai	ere autopsy findings ailable prior to mpletion of cause deeth?
<u>e</u>	icate l' 7r, pag	Con	roter							-	1 ☐ Ye		.6 10	Yes 2□ No
XII	s certif directo	To Be	25. Was cese referre examiner? 1 ☐ Yes 2 ☐ 1		Hospital:	Inpatient 2[2 ☐ ER/Outpatient	nt 3 DOA Othe	har	-	n <i>(Check only one</i> me 5□ Reside		-/Cnacif	
ion of	To the Hospital or Attending Physician: The is within 24 hours after death. To the Fuerel Director: After this certificate ha completely filled in by the funeral director, page	ation:	27. Manner of Death 1 ☐ Natural 2 ☐ Accident	th 5 Pending investigation	28a. Date o (Month	·	28b. Time of	f 28c. Injury Work	4 LT Nur	28	me 5 ∐ Reside 28d. Describe ho)
Divis	tal or Atter rs after der ei Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	d 28e. Place of buildin	ing, etc. (Spec	ecity)	reet, factory, office			28f. Location (Str City or Town	m, State)		
	the Hospif hin 24 hou the Funer mpletely fil	edicai	one)	2 Medical Exam	iminer: On the bas	e best of my kn asis of examin iner stated.	nowledge, death nation and/or inv	h occurred at the tim vestigation, in my op	opinion, death	d place, an	ed at the time, da	date and place	ice, and due to t	the cause(s)
	Will Co o	2	29b. Signature and t	itle of centiner.	1			29c. License	3 number		25	3d. Date sign	igned (Month, D	ay, Year)
		+	30. Name end addres	ess of person who	completed caus	e of death (If	tem 23e) (Type,	Print	90 P	3 34	1	11-	9-0	7
	3	1	Vilas R 31 Dete filed (Month	teade,	WD,	821	N Ew	bous St	-, S.	ule	308	Balt	imere	MD 21201
	State Registra	re	3) Rate illen farm	MAINLE	2004	gistrer's Sign	nature A	back	,				1	

DHMH 16 Rev 6/95

ORIGINAL

		-	State of Maryland Department of Health and Mo 1- State Registrar Certificate of Death	ental Hygi	ene 2004	35888
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) BENJAMIN COLLINS	2. Date of Death Month	Daynd Year	3. Time of Death
	Examin Funeral	er	Months Days Hours Min.	8. Date of Birth (Month, Day, 12-30-	4c. County of Death Alturyear) 9. Birthp Cour NC	n SPC lace (State or Foreign try)
	Director	-	239-38-2094 FEM 2LIF 74 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	12-30-		0d. Inside City Limits
	ne Maryla 8e-f ehov	Director	MD Lockhearn	10	g. Citizen of What Cour	1 Yes 2 No
	a or 2		10e. Street and Number 10f. Zip Code		SA	wy:
36	be filed within 72 hours after death with the Maryland Hygiene. do ther then "natural", or Items 23a or 28e-f ehow do ther then "natural", or Items 20a on 28e-f ehow event, the Medical Examinar must be notified at	by Funerai	3639 Forest Hill Rd. 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Argued Forces? 1 Syes 2 No If Yes, specify Cuban, Mexican, Puerto Forces of the Specific Syes of	cify Yes or No-	14. Race - Americ Black, White, Specify Blac	etc.
Maryland 21215-0036	within 72 hou ene. then "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+h 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Laborer 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ng	6b. Kind of Business/In	
12	filed with Hygiene. other ther		12th Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name			
land	outd be t Mental I arked of	To Be	James Edward Collins Addie B.			
Aary	2 sh and is m		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rural</i> 3639 Forest Hill Rd			Code) 207
	1 an Heal em 2		20a Method of Disposition 20b. Place of Disposition (Name of	-	Oc. Location - City or To	
E O	Pages nent of int: If It iry or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cametery, crematory or other place) Cantison Forcest Cem. 11/1	8/2004	Owings Mil	ls, MD
Baltimore,	permit. Pages Department of I Important: If It any Injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wes 2007 Eastern Ave	-		F.H 231
	100		23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failur. List only one cause in each line.	r respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. CERENADVAS LULAR THRD Due to (or as a consequence of):	MBOSIS		
P	Examiner		Caronde grande	ER.		
	be tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
,092	icate be executed physician and s the burial-transit	i Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
6876	ficate by physic s the b	edicai	d			
.O. Box (The law requires that the death certifica ate has been signed by the attending phoage 2 should be defached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delive Month	ory Day Year
Д	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to to s 2 □ No 3 □ Prot	-
I Records,		Completed		24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of 2000
Vital	Physician: Th this certificate al director, pag	Be (25. Was case referred to medical examiner? Hospital: CFD0 CFD0 Other: O	The same of the same		
of	Phys r this ral dir	5.	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	me 5 🗌 Resider 28d. Describe how	nce 6 Other (Specif w injury occurred	y)
ion	Attending Phy r death. ector: After thi by the funeral o	ation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division	in Diffe	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Rura , State)	l Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	te and place, and due to	the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier Dyly10 29c. License number Dyly10	1	d. Date signed (Month,	14 s
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEGINDER PI		21133	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	W. MIG		
	Regist	ar	NOV 1 5 2004 Bens & Sparks			

DHMH 17 Rev 1/2001

amend item#25,27,28a-f, perME, G842,476/05 TI State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 1 - For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Coffin Peter 26 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mailard Bay CareCenter Dorchester Cambridge, mo | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 19, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** China China 1 ☐ M 2 💢 F 92 Yrs 1912 **Director** 276-14-5027 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Dorchester Cambridge Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 520 Glenburn Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white þ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 is marked other th housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic events. William Wesley Peter Eleanor Whipple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 West End Avenue Cambridge, MD Deborah Kennedy/daughter 21613 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signatul Service Licensee Fonal d S. Wade Director Baltimore, MD 21201

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician preumonia /Medical Due to (or as a consequence of): Examiner tracture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical CERTIFICATION APPROVED BY MEDICAL EVALUNER IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Unknown dementic Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Oster porusis page certificate 1 Yes 2 INo Division of Vital Hos ital or Attending Physician: uneral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes -21 1/10 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Tatural Injury 5 Pending 1 Yes 2 XNo Aug. 2004 death. unk 2X Accident investigation Subject fell Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Revie Number, City or Town, State) Pallard Bay Care after 4 Homicide nursing home Center, Cambridge MD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) neun de 140059973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St, Cambridge MD 21613 100 Bramble Patricia 31. Date filed (Month, Day, Year) NOV 1 5 2004 32. Registrar's Signature State Registrar

			1 - For Stete Registrar	State of Ma	aryland / [rtment e ificate			and M	lental H	ygien Reg. N	ZIIIII	35890
	Physici /Medi		1. Decedent's Name (First, Middle, Las Doris J. Chan	berlin			el.				2. Date of E Month Novemb	Da	year 2004	3. Time of Death 2:25 A M
	Examir		4a. Facility Name (If not institution, give				4b. City, To	wn, or L	ocation o	of Death	·		County of Dea	
			Maplewood Park Pl				Beth			2411			Montgom	
	Funeral Director		5. Social Security Number 6. Se 505–10–6928	x //.Age ⊒M 21 <u>K</u>]F	e (In yrs. last bir 89	rthday) Yrs.		Days	If Under :	Min.	8. Date of B (Month, L November	irth ay, Year	9. Bir	thplace (State or Foreign ountry)
			Usual Residence of Decedent		0,5						November	. 0,1	913 N	ebraska
	show		10a. State 10b. County		10c. City, Tow	n or Loca	ation							10d. Inside City Limits
	h the Marylar r 28s-f show	Director	Maryland Montgome	ry	Bet	hesd	а						_	1 ☐ Yes 2 🛣 No
	무 오게	Dire	10e. Street and Number 9707 Old Georgetow	m Road			10f. Zip Co 208						tizen of What C	
	ns 23a	Funeral	11. Marital Status	12. Was Decedent E	ever in U.S.	13 Wa			nanic Orio	nin? (Sne	acity Vac or N		Lted Sta	
336	or Ite	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		1	Yes, specify Yes 2		Mexican Specify:	, Puerto	ecify Yes or N Rican, etc.)		Black, Whi	te, etc.
2-0	72 hours "naturel", dical Ex	Completed	15. Decedent's Edi (Specify only highest grad	ication	16a.	Decede	nt's Usual C	Occupati	ion		·	16b. F	(ind of Business	/Industry
21	- 28	nple	Elementary/Secondary (0-12)	College (1-4or 5			nd of work of NOT use i	retired)	ring most	or worki	ing			
121	be filed within ital Hygiene. Id other then event, the Me		17. Father's Name (First, Middle, Last)			Home	maker		0.14-15-	4. 11	/E:		wn Home	<u> </u>
Maryland 21215-0036	0 5 0 0	To Be	Henry Johnson						Gen	evie	ve Wal	lers	tedt	
Mar	ges 1 and 2 should it of Health and Mer I if item 27 is marke or other treumatic		19a. Informant's Name/Relationship (T) Mary E. Chamberli										or Town, State,	
	1 and Healt tem 2		20a. Method of Disposition	.ii/ Daugiite	20b. Place of cerneter						nardsv Date	,	ocation - City or	ersey 07924
JOL	Pages nent of I ont: If ite		1 ☐ Burial 2 ☆Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify,		cemeter	y crema Mont	tory or othe gomer orium	y place)			mber			
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre once.		21. Signature of Funeral Service Licens		M01356	22 N	Name and A	Address Pu	of Facility	ev I	Tuneral	Нот	iesda, M ie/Rockv	ille. Inc.
	COLUMN TO SERVE		23a. Part1. Enter the disease, or comp	ications that caused	the death. Do n	1300	west	Mon	ıtgom	ery	Ave.,	Kock	ville, l	Md. 20850 Approximate
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Вох	death certificate be executed e attending physician and id for use as the burial-transit	an/N	230. Was decedent pregnant	3c. If yes, outcome o		3∏ E 0	ctopic pregn	nancy				1	23d. Date of del	•
.O.	the dea by the at ached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□ Pregnant at t 9□ Unknown			Other (specif		-				Month	Day Year
α.	that the de ed by the a detached	Ph	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	the unde	erlving caus	e diven	in Part I		23e Did	tobacco i	ise contribute to	the cause of death?
Records,	w requires that been signed b should be deta	ted by	Anem	_				9,1011				Yes 2		obably 4 Dunknown
ec	a a c	Completed	0ste	oporosis							24a. Was	psy	prior to a	topsy findings available completion of cause of
	Th ate pag			n Cancer								ormed? 2⊠ No	death? 1 ☐ Yes	2 No
Vital		Ве	25. Was case referred to medical examiner?	lospital:				0.4			(Check only			
ō	Phys	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injury (Month, Day	nt 2 ER/Out		3□ DOA 28c.		- WITTUIN		ne 5 Resi		6 □Other (Spec	cify)
ion	Attending Ph r death. actor: After thi by the funeral	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) In	njury		Injury at Work?	s 2 🗆 N				,	
vis	r Atte er deg rector by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, far	rm, street	t, factory, of	fice		2	28f. Location (Street an	d Number or Ru	ral Route Number,
Ö	itel or rs afte rel Dir			building, etc.	(Opecity)						City of 16	wn, State	/	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sicien: To the best of ner: On the basis of and manner stat	examination and	, death or d/or inves	ccurred at th stigation, in r	ne time, my opini	date and ion, death	place, a occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	111	0 .	4.4		cense ni				29d. Dat	e signed (Month	n, Day, Year)
	N		1//whyn	Ven	rung	MUS	D3	3579	1			loven	ber 9,	2004
	10		30. Name and address of person who co					<i>u</i> -	_					
			Merlyn K. Vemury, 31. Date filed (Month, Day, Year)	32 Pagiffra		a Av	enue,	#22	7, S	ilve	r Spri	ng,	Marylan	d 20902
	Sta Registr		NOV 1 5	2004		4	rede	,						

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20	J		1 - For State Registrar	State of Marylar	nd / Depa <i>Ce</i> a	artment o	of Health of Death	and M	lental Hyg	iene 0 () L ₄	35891
	Physic /Medi		Decedent's Name (First, Middle, Last James	n Randolp	h	Chri	stophe	r	2. Date of Deat Month November	h Day	Year	3. Time of Death 8:17 A
	Examir		4a. Facility Name (If not institution, give 3817 Fernhill Ave	nue		Balti				4c. County		0.17 11
	Funeral Director		5. Social Security Number 6. St 219–26–2020 Susual Residence of Decedent	7. Age (In yrs. 65	Yrs.	If Under 1 Y Months D	ays Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day, O3 O4	^{Уваг)} 39	9. Birthr Cour M	
	ha Marylano 8a-f show ctified at	ector	10a. State 10b. County MD NA		ty, Town or Lo						1	0d. fnside City Limits 1 X Yes 2 □ No
	ath with th	Funeral Director	10e. Street and Number 3817 Fernhill	Ave		10f. Zip Co	21215		10	Og. Citizen of V		ntry?
9000	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or Itams 23a or 28a-1 show event, I're Medical Exertiner must be routiled at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Amed Forces? 1 Yes 2 No ff Yes, Give Year or Dates:		Was Decedent f Yes, specify			cify Yes or No- Rican, etc.)	14. Rad Blad Specify	ce - Americ ck, White,	ean Indian, etc. Black
21215-0036	d within 72 t glene. er than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) 4 yrs	(Give lite. L	dent's Usual O kind of work d DO NOT use re Urse	ccupation one during mos etired)	st of workii	ng	6b. Kind of Bi	pita	,
Maryland	should be filed vind Mental Hygie marked other tumaric event, III	To Be C	17. Father's Name (First, Middle, Last) William Russel 19a. Informant's Name/Relationship (7				Rub	у Ьо	(First, Middle, Merraine	Cheat	tham	
Baltimore, N	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or othar traumatic once.		James A. Christ 20a. Method of Disposition 1	Removal from State Me	Place of Disposementery, crem tro C:	sition (Name of natory or other remato Name and A arch	ory In	c. l St		0c. Location -	City or To	wn, State
58760,	that the death certificate be executed XE Wedpical Buy the attending physician and detached for use as the burial-transit	edical Examiner	23a. Part1 Enter the disease, or comp shool, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ications that caused the death ne cause on each line. Arterioscle Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	Protic (uence of):	er the mode of	dying, such as	cardiac or	respiratory arres			Approximate Interval Between Onset and Death
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Records, P.	ed ed	by	Part II. Other significant conditions co	ntributing to death but not rest	ulting in the un	derlying cause	given in Part I.		23e. Did toba			e cause of death?
_	The ate h page	e Completed	25. Was case referred to medical							No 1	Vere autop rior to com eath? Yes 2	sy findings available pletion of cause of
o	ktending Phys death. ctor: After this / the funeral di	Certification: To Be	27. Manner of Death 1	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of fnjury	28c. lr	Other: 4 Nu njury at Work?	rsing Hom 28 No	(Check only one) e 5 Resident Bd. Describe how Bf. Location (Stre.)	ce the injury occurre	ed	de Sourc
2	spital or ours afte ours afte seral Dir filled in		29a. Certifier 1 ☐ Certifying Phy.	building, etc. (Specify	vledne death	Occurred at the	a time, date and	d place an	City or Town,	State)		A
>	To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medicef Exami	ner: On the basis of examinat and manner stated.	ion and/or inve	29c. Lice	ense number O.C.M.E	h occurred	at the time, date	Date signed	nd due to t	he cause(s) ay, Year)
	Stat	te	30. Name and address of person who co	mp d cause of death (Item		,		et, E	altimore	e, Mary	land	21201

			1 - For State Registrar	State of Marylar		artmen <i>rtificat</i>			and M	entai	Hygie Reg.	7111	L,	35892)
	Physici		1. Decedent's Name (First, Middle, Last)		DA	411	S		2. Date Mont		Day 7	Year	3. Time of Death	
	/Medio Examir		4a. Facility Name (If not institution, give Valversity of Mayla		enter		Town, or	Location o	of Death	100		4c. County	of Death	A	
	Funeral Director		5. Social Security Number 6. Se 216 - 24 - 5246			If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date (Mon 04	of Birth	ear)	9. Birthpl Count	ace (State or Fore	ign
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation 34 LT	iMo	re					10	0d. Inside City Lim	
	3a or 28a	i Director	10e. Street and Number 1734-N. PAYON	STREET		10f. Zip		121	7		10g.	Citizen of W	/hat Count	try?	
920	be filed within 72 hours after death with the Maryland hal Hygiene. do other than "natural", or items 23e or 28e-f show event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 SNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deced If Yes, spec		spanic Origin, Mexican	gin? (Spe , Puerto F	cify Yes Rican, et	or No-		- America k, White, e		
21215-0036	filed within 72 ho Hygiene. Ither than "natur ont, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usua kind of wo DO NOT us PAL	rk done d se retired)	luring most)				HEAL		•	
Maryland	should be file nd Mental Hy i marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) LUMMIE DAV	'IS				Q	4D'	(S	THO	den Sumam MAS	>		
	s 1 and 2 should f Heelth and Mer item 27 is marke other treumatic			2/SISTER		N. P	4 Y50		TRE	et	BAL	ty or Town, . TO, M	02	1217	
Baltimore,	Page nent o ant: if ury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		emetery, crer ARE	NTUS	ther place	´ ¦	11-10		f B	ALTIA	1020	·, MD	
Bal	permit. Depertr Importe any inj		21. Signature of Funeral Service Licent		<u> </u>	Name and AUG	Address HN I	s of Facility	cen	RE	UNE	RALS BAL		10-21225 D 21225	ì
i.	Pnysician /Medical		23a. Part1. En(a) the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Intrace	rebr	al	11	MOV	- 1					Approximate Interval Between Onset and Death 3	2
18760,	cate be executed physician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence). Due to (or as a consequence).	PNSI	01								1 mouth	
.O. Box 6	death certifi e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pr Other (sp						23d. Date Mon	of deliver	y Day Year	
rds, P	signed be de	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e.		1		cause of death?	vn
Vital Records,		Completed									Was an autopsy performed	?/ de	ere autopo for to come eath?	sy findings availab pletion of cause o	le f
Vita	Physicien: This certificated in director, p	Be	25. Was case referred to medical examiner?	lospital:			Otho	26. Place			-				
of		ion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	2	8c. Injury Work	at ?	28			6 □Othe			
Division	ten deat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	M eet, factory		es 2 🗆 N		3f. Locat City o	ion (Street r Town, St	and Numbe ate)	r or Rural	Route Number,	
	To the Hospitei or Al within 24 hours after of To the Funerei Direc completely filled in by	edicai C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, death	l place, ar h occurre	nd due to	the cause ime, date	o(s) and man and place, a	ner as sta nd due to t	ted. he cause(s)	
•	To the within 2. To the complet	Me	29b. Signature and title excertifier	M.D.			License					Date signed			
	9		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)			ine	M					
T.	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 5 2004	32. Registrar's Signa	ture	Spain	12/			-			,		

		For State Registrar		State of	Maryla	nd / Dep <i>Ce</i>	artme <i>rtifica</i>	nt of H	lealth and Death	Mental H	ygier Reg. N) 4	35893
Dhusisi		1. Decedent's Nam	e (First, Middle, L	ast)						2. Date of I			2011	3. Time of Death
Physici /Medic		Mai	rie L.	Doyle						Novem	ber ˈ	6, 20)04	9:40 p
Examin		4a. Facility Name (I	f not institution, g	ve street and numb	ber)		4b. City	, Town, or	Location of Dea	ith	4	c. County	of Death	
			Maris Ho	ospice			Timonium						more	
Funeral		5. Social Security N				s. last birthday)	If Unde	Days	If Under 24 Hr Hours Mir	S. 8. Date of E	Rinth			lace (State or Foreig
Director		214-36-87	10	1□ M 25√F	68	Yrs.	11	5,0		March	18,	1936	Nica	ragua
and w		Usual Residence of 10a. State	10b. County		10c. C	City, Town or Lo	ocation							Od Insid On II is
after death with the Maryland or items 23s or 28s-1 show ciliber roust be notified at	ō	Florida	Palm Be	aach	1	-		مام						0d. Inside City Limits 1 ☐ Yes 2 ☑ No
28a-	Director	10e. Street and Nur		acii	N.	est Pal		D Code						
with	ă		eronwood	Lana							1	itizen of W	Vhat Cour	itry?
eath w	Funeral	11. Marital Status	er onwood	12. Was Deced	ent Ever in I	118 112		33412		0		USA		
fter dea	Fun		ied 2 Married	Armed Forc	es?		If Yes, spe	cify Cuba	n, Mexican, Pue	Specify Yes or Nato Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.			
urs af	by	3 🗆 Widowed		If Yes, Give Year or Date	• •		1 XYes	2 🗆 No	Specify: Ni	caraguai	n	i to		
"natural"	ted	-	15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occupa	ition		16b. Kind of Business/Industry			
hin 7	ble	Elementary/Seco	ndary (0-12)	ade completed) College (1-4	or 54)	(Give	kind ol w DO NOT i	ork done a ise retired,	luring most of wo	orking				200117
filed within 72 hours Hygiene. yther then "naturel", ent, Ire M. Alcel Ex.	Completed			1		Home	Make	er			01	me		
al Hy al Hy oth	Be (17. Father's Name	(First, Middle, Las			18. Mother's Na	тө (First, Middi							
Venti	To	Ernesto Peugnet Rosa Ana Lopez												
and land		19a. Informant's Na				19b. Mailir	ng Addres	s (Street a	nd Number or F	ural Route Num	ber, City	or Town, S	State, Zip	Code)
and 2 salth n 27 i		Mr. Donal	d Doyle/	Husband		10302	Her	onwoo	d Ln. W	est Palr	n Be	ach,	Fl.	33412
permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "ni any injury or other traumatic event, If a Musi one.		20a. Method of Disp		☐Removal from St	20b.	Place of Dispo	sition (Na	me of other place	9)	Date	20c. I	Location - (City or To	wn, State
Pag ment ant: I		`4 □Donation	5 Other (Speci	fy)	Du	laney V	-			0/04	Tim	onium	ı. Ma	ryland
permit. Departi	1	21. Signature of Fu	neral Service Lice	nge C		-			s of Facility					k Road
89 = 89		1	X / 7	1/2		Ru	ick T	owsor	Funera	1 Home,	Inc	. Tows	on M	d.21204
Physician /Medical		23a. Part1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	Final	a. LUNG	sed the dea h line. CANCE	ER	er the mod	de of dying	, such as cardia	c or respiratory	arrest,			Approximate Interval Between Onset and Death
Examiner and II-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
physicia the bu	edlcal E	Due to (or as a consequence of):												
Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/M												y Day Year	
s tha	by P	Part II. Other signifi	cent conditions	contributing to deat	h but not res	sulting in the ur	derlying o	ause givei	n in Part I.	23e. Did	tobacco	use contrib	oute to the	cause of death?
quire n sig uld b			Ng.							1 🗆	Yes 2	□ No 3	B 🔲 Proba	bly 4 🛣 Unknown
w requir s been si should	lete									24a. Was	20	24b W	oro auton	
ician: The lav certificate has rector, page 2	Completed									auto		pri	or to come ath?	sy findings available pletion of cause of
ysician: is certific director,	Be	25. Was case referre		Hospital:				-	_	ath (Check only				
ding Phys h. After this funeral di	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify									HOSPICE				
al or Attending s after death. al Director: After ed in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 6 City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										or Rural	Route Number,	
hs Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one)	1 Certifying Pt 2 Medical Exar	ysician: To the be niner: On the basis and manner	st of my kno of examina stated.	owledge, death ation and/or inv	occurred estigation	at the time in my opi	, date and place nion, death occu	, and due to the rred at the time,	cause(s date and) and manr d place, an	ner as sta	ted. he cause(s)
o H o E		29b. Signature and t	itle of certifier				290	. License	number		29d. Da	te signed (Month, D	av. Year)

9:40 p.m.

NOVEMBER 6, 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

MARIE DOYLE

29c. License number D43725

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

State Registrar

within 24 hours a To the Funeral I

			1 - For State Registrar		Marylar			t of H	ealth a		ental Hygi		n L	35894
	Physici	an	1. Decedent's Name (First, Middle, I	.ast) Doroth	v Jean	Di	ggins				2. Date of Deatl Month	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, o					Town or	Location of		lovember	7, 20 4c. County		9:10 P M
	LXamii	ici	6730 Pine Avenu		,			nda1		Death			timo:	ro.
	Funeral		Social Security Number 6.		. Age (In yrs.	last birthday)	If Under Months			24 Hrs. 8	B. Date of Birth (Month, Day,			place (State or Foreign htry)
	Director		220-20-6810 Usual Residence of Decedent	ILIW ZXIF	75	Yrs.			Tiouis .		pril 9,			yland
	yland now		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	Od. Inside City Limits
	e Mar	ctor	Maryland Ba	ltimore]	Dundal	1 k				1 ☐ Yes 2√2 No
	vith th	Director	10e. Street and Number				10f. Zip				10	g. Citizen of	Whal Cour	ntry?
	eath v	era	6730 Pine Ave	nue	ant Francis II	0 10			1222			ited S		
ထ	after d or Item rings	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	Armed Force	es?	.5.	f Yes, spec	ify Cuba	n, Mexican,	Puerto Ri	fy Yes or No- can, etc.)		ce - Americ ck, White,	
93	72 hours after death with the Maryland natural', or Items 23a or 28a-f show digal Ezairers must be notified at	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat			1 ☐ Yes 2	2 □ No	Specify:			Specifi	y: WI	nite
21215-0036	"natu	Completed	15. Decedent's (Specify only highest g			(Give	dent's Usua kind of wor	k done d	urina most i	of working	1	6b. Kind of B	usiness/Ind	dustry
12	withir ene. than	dmc	Elementary/Secondary (0-12) 12 Years	College (1-4	or 5+)		DO NDT us	,				~		
שַ	other	Be C	17. Father's Name (First, Middle, Las	it)			гетерг	lone	Opera 18. Mother		First, Middle, M.	Commun		lons
ylar	Menta Menta arked atic e	To E	George William	Dakin					Ali	ice R	eynolds			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating mather prolified at once.		19a. Informant's Name/Relationship		- ala - al						Route Number,			
e,	1 and Healti iem 27		Mr. Gerald T. D	1991ns/H		1ace of Dispo			e. Du	inda I Dat	k, Mary		21222	
Baltimore,	Pages ant of nt: If it		1 Burial 2 Cremation 3		ate	emetery, cren	natory or ot	her place	· .			Dc. Location -		
alti	mit. F partm portar portar / injur		21. Signature of Funeral Service Lice			22	. Name and	Address	of Facility			Towson		-
m	S T D D D D D D D D D D D D D D D D D D		Mye C	· (au	00		7022 t	Tico	7777	Dunc	ome of Malk, Ma	arvland	k, Ir 1 21	nc. 222
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cau one cause on eac	sed the death h line.	n. Do not ent	er the mode	of dying	, such as ca	ardiac or r	espiratory arres	it,		Approximate Interval Between
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CO/2	m ce	anc	er							Onset and Death
Н	Examiner			Due to (or	as a consequ	uence of):								
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequ	uence of):								
バ	ecuter and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									}	
150928	cate be executed physician and the burial-transit	al E		Due to (or	as a consequ	Jence of):								
Ö	ificate g phys	edlcal		d										
Box	death certifica e attending pha of for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pre	co anal				23d. Date	e of deliver	у
о. П		/slci	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		t at time of de		Other (spe	cify)				Mor	nth I	Day Year
<u>a</u>	The law requires that the tite has been signed by the page 2 should be detached.		Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the un	derlying ca	use giver	in Part I.		23e. Did tobai	cco use contr	ibute to the	e cause of death?
rds	w requires been sign should be	9						3			1 ☐ Yes			bly 4 □Unknown
ဝ၁	law re	plet									24a. Was an	24b. W	Vere autop	sy findings available
Ž		Completed									autopsy performe 1 Yes 2	di d	rior to com eath? □ Yes : 2	pletion of cause of
Vital Records,	ician: Th	Be	25. Was case referred to medical examiner?	Hospital:							heck only one)			
ō	or Attending Physician: ther death. Director: After this certific in by the funeral director,	<u>آ</u> :ر	1 Yes 2 D No 27. Manner of Death	1 □ Inpa		ER/Outpatient 28b. Time of		c Injury a	4 □ Nursi	ing Home	5 Residence	e 6 Othe	r (Specify)	
0	nding I ath. r: After e funer	atlor	1 Pending 2 Accident 5 Pending investigation	28a. Date of I (Month,	Day Year)	Injury	м	c. Injury a Work? 1 □ Ye	s 2 □ No	- 1	. Doscribe now	mjury occurre	ou .	
Division	after death Director: d in by the	Certification	3 Suicide 6 Could not to determined	280. Place of	Injury - At hore	me, farm, stre	et, factory,	office		281.	Location (Stree City or Town, S	et and Numbe	or or Rural	Route Number,
	ral led									1		,		
	e Hospital of 24 hours at e Funeral Dietely filled i	Medical	29a. Certifier 1 Vertifying Pl (Check only 2 Medical Exa	nysician: To the be miner: On the basis and manner	o oi examinati	vledge, death ion and/or inv	occurred at estigation, in	the time n my opir	, date and p nion, death	olace, and occurred a	due to the caus at the time, date	e(s) and man and place, a	ner as sta nd due to t	ted. he cause(s)
	To the Hos within 24 ho To the Fun completely f	Me	29b. Signature and litle of certifier	2				License i				Date signed		
•			Nan tal	emir	N.D		1	000	53	07	0 1	1/8/	20	04
	. n		30. Name and address of person who	completed cause of	f death (Item	23a) (Type, P	rint)							
	10	2	401 N. Broadu 31. Date filed (Month, Day, Year)		strar's Signati	ove, v			231	<i>-</i>				
	Stat Registra	e ar	31. Date filed (Month, Day, Year) NOV 1 5 2	004	مصمور	6	Los	2	,					

			1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and M <i>rtificate of Death</i>	lental Hygie Reg.	2004 35895
-			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Doris Claribel Denhard		Nov. 12,	^{Day} 2004 Year 9:30 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			702 Goucher Ave.	Lutherville If Under 1 Year If Under 24 Hrs.	O Data of Birth	Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 13,	9. Birthplace (State or Foreign Country) 1924 Maryland
	ס		Usual Residence of Decedent			
	arylar show	<u> </u>	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 【 No
	the M	ecto	MD Baltimore Luthervi	10f, Zip Code	100.	Citizen of What Country?
	3a or	Funeral Director	702 Goucher Ave.	21093		nited States
	death	nera	11 Marital Status 12, Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
20	within 72 hours after death with the Maryland ane. ttan "natural", or items 23a or 28a-f show he Jigal Examinar must be notilied at	by Fu	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 🛣 No Specify:	,,	Specify: White
21215-0036	2 hour		15 Decedent's Education 16a Dece	dent's Usual Occupation	166	b. Kind of Business/Industry
N .	thin 7: e. en "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ing	
7	ygien ygien her th	Con	12 Homer		e (First, Middle, Maid	Own Home
yland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Examination and the routing all angles.) Be	17. Father's Name (First, Middle, Last) Charles W. Donnelly	June Rob		den Sumame)
2	should nd Me mark mark	2	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rura	al Route Number, Ci	
, Mar	and 2 alth al 27 is er treu		Donald M. Denhard/husband 702	Goucher Ave. Lut		
ore	jes 1 a of He if Item or oth			matory or other place) 11/1	6/2004	Location - City or Town, State
sairimore,	it. Pag rtment rtent: njury			alley Mem. Garons.	1	imonium, Maryland
g	perm Depa Impo any i		S Coeter	1050 York Road, To		n Funeral Home, Inc.
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate Interval Between
ì	Physician		Immediate Cause (Final disease or condition	who acciden)	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	000		
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	Man		
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. Olympic Sna	in Syndrowe		
Ď,	cate be executed physician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
28/60	physicate to physicate to physical street.	edical	d			
XOR	death certifi e attending id for use as	n/M	IF FEMALE: 23b. Was decedent pregnant 1 □Live birth 2 □ Fetal death 30	□Ectopic pregnancy		23d. Date of delivery
	w requires that the death certific been signed by the attending f should be detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
r Ö	hat the od by the detacher		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ds,	requires that een signed b hould be deta	d by			1 🗆 Yes	2 No 3 Probably 4 Unknown
Hecord	law req as beer 2 shou	Completed			24a. Was an	24b. Were autopsy findings available
	9 4 9	mo			autopsy performed 1 ☐ Yes 2 X	prior to completion of cause of death? 1 Yes 2 No
VItal	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?		(Check only one)	
01	d is	To	1		me 5 Residence 28d. Describe how in	6 Other (Specify)
	ding h. After fune	tlon	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No	200. 0000100 1101111	nuly occurred
UIVISION	or Attending after death. Director: After in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, st. building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
5	ital or A	O				
	To the Hospital or within 24 hours afte To the Funerel Dil completely filled in	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deat (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, ivestigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comple	Med	29b. Signature and title of gertifier	29c. License number		Date signed (Month, Day, Year)
•			1 /Wace//Arton	032929		11/15/04
	b		30. Name and address of person who completed cause of death (Item 23a) (Type, Ry JAND 6. DANTONO, MO 7300)	Print)	on The	11/15/04 Sm mo 21204
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	how to	1 100	720
	Registr		31. Date filed (Month, Day, Year) NOV 1 5 2004 32. Registrar's Signature	bedraces		

State of Maryland / Department of Health and Mental Hygiene 0 35896 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:00 a Edith Belle Farrell /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2802 Park Ave. Manchester Carroll 9. Birthplace (State or Foreign Country) Hary Land If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) DeC. 19 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 1 F 218-22-4084 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show the Medical Examiner must be notified at 1. Yes 2 No Maryland Carroll Manchester Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 2802 Park Ave. 21102 U.S.A. "neturel", or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or item eny injury or other treumatic event, ILA Musical Education. 1 Never Mamied 2 ☐ Married 1 ☐ Yes 2 Ē No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be May A. Kennedy Elmer E. Bosley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2802 Park Ave. Manchester, Md. 21102 William Farrell, Sr. - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gardens Nov. 17,2004 Timonium, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Ckhardt Funeral Chapel P.A. 296 Charmil Dr. Manchester, 21. Signature of Funeral Service Licensee State Elles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician مبدير جدا /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Phyaician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Type 2 THO be detached 9 Unknown Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? has 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated the 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature and 3316 5 15 1 1 nd address of person who completed cause of death (Item 23a) (Type Print)

There is the first of the completed cause of death (Item 23a) (Type Print) 30. Name and address 31. Date filed (Month, Day, Year) 5 2004 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

English

State of Maryland / Department of Health and Mental Hygier [2] 35897 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Vear **Physician** Russell Wilbur November 4, 2004 11.15am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O 2 | O 4 | 2 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 231-12-0727 79 ۷a Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other then "natural", or Items 23e or 28e-f shov treumatic event, the Meulcal Examiner must be multified at 1X Yes 2 No Director MD Baltimore NA 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 3319 Kerry Road 21207 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after tX Xes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Juvenile Services State of Maryland 10th grade na permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other treumatic event, sones. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Ford Mary Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Ford-Wife 3319 Kerry Road, Baltimore, Md 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State ^ 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 11/12/04 Owings Mills, Md 22. Name and Address of Facility
March F/H West Funeral Service Licensee 4300 Wabash Ave, Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bilateral Broncho-pneumonia Four Weeks. /Medical Due to (or as a consequence of) Examiner Stroke Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Venner. Due to (or as a consequence of) Examiner death certificate be executed burial-transit Hypertension Years. Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Senile Dementia. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform-1 ☐ Yes 2 🖾 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Hospitel or Attending P
 24 hours after death.
 Funerel Director: After the Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) 24 hours a 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2-29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 30469. November 5, 2004. O. Name and address of person who B Vellanki, MD; who completed cause of death (Item 23a) (Type, Print) 9055 Chevrolet Drive, #Suite 100, Ellicott City, MD 21042. 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 16b per 11 9837 11-15-04 vt
State of Maryland 7 Department of Health and Mental Hygiene 35898 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav 45 AM Donald Foy, Jr. 9 Nov. 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Yee Nov. 277, Harborside Gardens Nursing Home 5. Social Security Number 216-98-4352

Birthplace (State or Foreign Country)
 Mass.

7^{Yeer} 1968

/Medical Examiner

Funeral

Director

Physician

1 - For State Registrar

6. Sex

1**№** M 2□ F

7. Age (In yrs. last birthday)

35

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Items 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examinar must be indiffied at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Usual Hesidence of Decedent						
	10a. State 10b. County	10c. City, Town or L	_ocation				10d. Inside City Limits
10	Maryland N/A		Baltimor	·e			1 XYes 2 ☐ No
le C	10e. Street and Number		10f. Zip Code		100.0	itizen of What Co	untar?
ō	6221 Fair Oaks Avenue			4			unu y r
B	ozzi idii oaks Avenue		2121	4	U	SA	
Funeral Director	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Speci In, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ame	
14	Mover Married 2 Married 1 Yes 2 the Yes, Give	10	1 ☐ Yes 2 ☒ No		outi, otc.)	Black, White	lack
þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		TU Yes 26 No	Specify:		Specify: D	lack
ted	15. Decedent's Education	16a. Dece	edent's Usual Occup	ation	16b.	Kind of Business/	Industry Public
ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	e kind of work done of DO NOT use retired	during most of working			City Publ
E	Elementary/Secondary (0-12) College (1-4or 5		ool Teac	hor		nools	CICY TUDI
Ü	17. Father's Name (First, Middle, Last)		oor reac	18. Mother's Name (
To Be Completed	Donald Foy, Sr.			Gwendol		77 SUTTAINE	
F							
	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street a	and Number or Rural F	Route Number, City	or Town, State, Z	ip Code)
	Bessie Peacock/ Adopted	1 0221	rair O	aks Ave I	saltimor	re, Mar	yland21214
	20a. Method of Disposition Mother	20b. Place of Dispo	osition (Name of ematory or other place	e) 11/13/	20c. I	ocation - City or	Town, State
	1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)		n Cemete	" 11 / 13 / rv	04 Bal	timore	Ma 1
	21. Signature of Funeral Service/Licensee			- ,	Dal	cimore	, Maryland
	21. Signature di Funeral Service/Closisee	2.	2. Name and Addres	s of Facility Chat	man-Har	ris Fu	neral Home
_	Mry Hor					timore	, Md21215
	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not en	iter the mode of dying	g, such as cardiac or r	espiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition A	25					Onset and Death
	resulting in death)	a consequence of):					
	Due to tor as	consequence or):	Dea	la			
L.	Sequentially list conditions, b.	such	- 400	me			
ine	cause. Enter Underlying	a consequence of):	10 1	amic	Attach		
am	that initiated events	mount	1800	amic	Moralen		
ũ	Due to (or as a	a consequence of):					
ca	d	eyme					
ed		0					
3	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome					23d. Date of deliv	1001
cia	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
ysi	1 Yes 2 No 4 Pregnant et 9 Unknown 9 Unknown						
4	Part II. Other significant conditions contributing to death but	t not resulting in the u	indertying cause awa	n in Part I	220 Did tobacco	use contribute to	the cause of death?
b	[[]	thetrooding in the d	moonying oddse give	THE FAILT.			
ted	Toranne				1 ∐ Yes 2	□No 3□Pro	bably 4 Etinknown
pie					24a. Was an	24b. Were aut	opsy findings available
Completed by Physician/Medical Examiner					autopsy performed?	prior to co	emptetion of cause of
a	25. Was case referred to medical			00 81-11	1□ Yes 2□No	1 □ Yes	2 ∐ No
00	examiner?		Othe	26. Place of Death (C		12.0	
.To			IL 3L DOA	4 Mursing Home			fy)
lon	1 ⊟Natural 5 ☐ Pending (Month, Day	Year) 28b. Time of Injury	Work	at 280	. Describe how inju	ry occurred	
cat	2 Accident investigation		M 1 □ Y	es 2 No			
	237100100111	ry - At home, farm, str	reet, factory, office	28f.	Location (Street as City or Town, State	nd Number or Run	al Route Number,
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Certif	3 Suicide 6 Could not be 28e. Place of Inju	(Specify)					
al Certif	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Inju building, etc	f my knowledge death	h occurred at the time	e, date and place, and	due to the cause/s	and manner as	stated
dical Certif	3 Suicide 6 Could not be determined 28e. Place of Inju	f my knowledge, death	h occurred at the time vestigation, in my op	e, date and place, and inion, death occurred a	due to the cause(s) and manner as s d place, and due t	stated. o the cause(s)
Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Inju building, etc 29a. Certifier (Check only 2 Medical Examiner: On the basis of	f my knowledge, death	h occurred at the time vestigation, in my op	inion, death occurred a	it the time, date an	d place, and due t	o the cause(s)
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e Medical Certif	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Inju building, etc 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of and manner stat 29b. Signature and title of certifier 30. Name and address of person who completed cause of de	f my knowledge, death examination and/or inved. VN 1) ath (ttem 23a) (Type, Carry Signature	29c. License	number	29d. Da	te signed (Month,	Dey, Year)
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Sta

Registrar

State of Maryland / Department of Health and Mental Hygiene 35899 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 7, 2004 **Physician** William Eyre Fordyce /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 79 Yrs. Director 005-84-0413 June 15, 1925 Guyana Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , or items 23a or 28a-f show ar doer must be notified at Lanham 14 Yes 2 No Prince George's Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5508 Axton Court 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Event once. Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing (Unknown) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Fordyce William . (Unavailable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5508 Axton Court, Lanham, MD Garie A. Fordyce / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 10, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 2004 Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral and Cremation Services 21. Signature of Funeral Service MOO382 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 □ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sl autopsy performed: 2 No 1 Yes 2 2 No 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director:. completely filled in by the t 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 B ann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave., Takoma Park, MD Deanna White, M.D.; 31. Date filod (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artmer <i>rtificat</i>	t of Healti e of Dea	h and M <i>th</i>		ien 200	4 35900
ľ			Decedent's Name (First, Middle	e, Last)						2. Date of Deat Month	h	3. Time of Death
	Physicia /Medic			Ah-	-Chu Fan	L					er_{10}^{Day}	004 12:40 AM
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City,	Town, or Location	on of Death		4c. County of	Death
1				rning Dov			4/11-1-		ersbu			ntgomery
	Funeral		5. Social Security Number	6. Sex 11 M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	Months	1 Year If Uni Days Hou	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		220-94-5845 Usual Residence of Decedent		86	113.				April 26.	, 1918	Taiwan
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Man	tor	Maryland Mon	tgomery				Gaithe	rsburg	3		1 ☐ Yes 2 🌠 No
	th the	Director	10e. Street and Number				10f. Zij	Code		10	0g. Citizen of Wha	at Country?
	23e (23e (23e (23e (23e (23e (23e (23e (ai C	8836 Mou	rning Dov	re Court				879			ed States
	tems	Funerai	11. Marital Status	Armed F		J.S. 13.	Was Dece f Yes, spe	dent of Hispanic cify Cuban, Mex	Origin? (Spacican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
0000	rs afte	by F	1 ☐ Never Married 2 📉 Marr 3 ☐ Widowed 4 ☐ Divorced	ned 1 ∐ Yes If Yes, G Year or	: 2 🔯 No Sive Dates:		1 🗆 Yes	2⊠ No Spec	city:		Specify:	
3	2 hou		15. Deceden	t's Education		16a. Dece	dent's Usu	al Occupation			16b. Kind of Busir	Asian ness/Industry
<u> </u>	nin 72 n " ni Medili	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of wo	rk done during n se retired)	nost of work	ing		
7	giene grant	Com	6	303			Kito	hen Ass	istant		Re	staurant
and	at Hy d oth	Be (17. Father's Name (First, Middle,	Last)				18. Mo	other's Name	e (First, Middle, N	Maiden Sumame)	
Х	ould I Meni warke	To		Ah-Da I	an						n Mei Wei	
Mar	12 sh h and 7 le m treum		19a. Informant's Name/Relations				•	,		•	City or Town, Sta	
a) 	1 and Health em 2 ther		Lan-Ying Brown 20a, Method of Disposition	/ Daughte	20b. l	Place of Dispo	sition (Na	me of			irg, Mar 20c. Location - Cit	yland 20879 by or Town, State
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 le marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, it is Medical Examinating the notified at once.		1 X Burial 2 ☐ Cremation		n State	cemetery, crer			Nov	ember 2004	D -1 '11	
апптог	artme artme ortan injury		 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service 		Par	22	. Name a	<u>ial Park</u> nd Address of Fa	acility Rob	ert A. P	umphrev	<u>e, Maryland</u> Funeral Home/
Ď	Depar Impor any ir			776	№ мооз	35 R	ockvi ockvi	lle; Ma	c.300 ryland	Westo ^M	antgomér 2805	y Avenue
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	only one cause on		KINS	MOS	((7	DISE	ASE		Onset and Death
	/Medical		resulting in death)	aDue to	o (or as a consec	quence of):						12/01/13
Ľ	Examiner		Sequentially list conditions.	b		•	Es	MELL	ITI	15		10 YEARS
٦	sit sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a consec	quence of):						
	and and M-tran	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a consec	quence of):						
00/9	death certificate be executed e attending physician and od for use as the burial-transit	dicai E										
00	ficate g phy: as the	au l		d								
Z O X	n cert anding use a	In/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Ectopic p	regnancy			23d. Date o	
D	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of o		Other (s)				Month	Day Year
)	at the	Physician/M	9 Unknown			- data - 1 - ab				22a Did tah	ann una contribu	ite to the cause of death?
Š,	sicien: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	by	Part II. Other significant condition	ons contributing to	death but not res	sulling in the u	nderlying (ause given in Pa	an I.			☐ Probably 4 ☐ Unknown
Records	neen s	Completed								-		
e C	has b	mpi								24a. Was ar autopsy perform	/ prio	re autopsy findings available r to completion of cause of th?
_	n: The ficate har, r, page	e Co	25. Was case referred to medical					00.00		1 ☐ Yes 2		Yes 2 No
	Physicien: this certificated director,	0 B	examiner?	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 D	Other		n <i>(Check only one</i> me -5 K ∩ Besidei	nce 6 □Other ((Specify)
0	g Phys er this ieral dii	n: T	27. Manner of Death	28a. Date	e of Injury onth, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe ho		
0	anding Fath. ar: After ne funer	atio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	injuly	М	1 ☐ Yes 2	2 □ No			
DIVISION	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Plac	ce of Injury - At h ding, etc. <i>(Speci</i>		eet, factor	y, office		28f. Location (Str City or Town		or Rural Route Number,
2	pitel c		CO- O- William A M Co-differen	a Dhuaisian Tari								
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate in completely filled in by the funeral director, page	edicai		ig Physicien: To the Examiner: On the and ma								
	ro the	Me	29b. Signature and title of certifie	7)		29	c. License numb	er	29	d. Date signed (A	Month, Day, Year)
		,						20044	-513		Novembe:	r 10, 2004
	17		30. Name and address of person		use of death (Iter	m 23a) (Type,	Print)	20000	Parkis	THE MAN	AND DARE	Suite 202 (301)990-3190
			SANG - KYUNE 31. Date filed (Month, Day, Year)	ut, n	Registrate Sign	SMADY	yKO VC	KNAD	VOCK.	100, "K	7000	(301)990-3190
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			For State Registrar	State of Marylan		artment of			ygiene 0	04	359	01
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of D Month	Day	Year	3. Time of	
	/Medic	al	Elizabeth Frick 4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tow	n, or Location	Novembo of Death	er 9, 20		9:15	A M
	Examin	er	Wilson Health Care				rsburg		1	gome	rv	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Ye Months Da	ar If Under	24 Hrs. 8 Date of B	irth (av. Year)	9. Birthp	place (State or	
L	Director		Usual Residence of Decedent	M 281F 83	Yrs.			December	5, 1920	Penns	ýlvani	.a
	yland sow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	10d. Inside Cit	y Limits
	e Mar	ctor	Maryland Montgomer	ry Ro	ckville	e					1 🛣 Yes	2 No
	vith th	Directo	10e. Street and Number			10f. Zip Cod			10g. Citizen of	What Cour	ntry?	
	eath v	Funeral	600 Mercer Road	2. Was Decedent Ever in U	S. 13. V	2085		igin? (Specify Yes or N	United	State		
9	filed within 72 hours after death with the Maryland Hygene. other than "natural", or Items 23e or 28e-f show ent, the Medical Examinar must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No	1	fYes, specify (1 ☐ Yes 2 🔯 I		igin? (Specify Yes or N n, Puerto Rican, etc.)		ck, White,	etc.	
003	ural',	d by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:						y:Whit		
15	n 72 h "natu edice	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	tent's Usual Oc kind of work do DO NOT use re	ne during mos	st of working	16b. Kind of B	usiness/Ind	dustry	
212	d withi	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Hon	nemaker	,		Own H	lome		
ם	al Hyg	ВеС	17. Father's Name (First, Middle, Last)					er's Name (First, Middl				
Maryland 21215-0036	nould to	Į,	William Craven Ri		405 14-25			beth Marth			0-4-1	
Ma	d 2 st th and t7 Is n traun		19a. Informant's Name/Relationship (Ty) Marsha E. Lasley		4.	-		er or Rural Route Num. oad, Derwoo				
re,	s 1 an f Heal item 3	Ì	20a. Method of Disposition	20b. F	lace of Dispo	sition (Name or natory or other	7/2021	Date	20c. Location			
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)			ery um, Inc		November 11, 2004	Bethesda	a, Ma	ryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Department of Health and Mental Hygene. The proportent: I firem 27 is marked other transmit in a Medical Examinat must be rectified at any injury or other transmatic event, the Medical Examinat must be rectified at ODCs.		21. Signature of Funeral Service License License		Ro	Name and Adobert A	dress of Facili Pumph	irey Funera omery Ave.,	1 Home/F Rockvil	lockvi le, 1	ille, 1 Md. 208	Inc. 350
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	e cause on each line.							Approximate Interval Betw Onset and D	veen
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Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/M	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3□	Ectopic pregna Other <i>(specify</i>				ite of delive onth	,	'ear
Q.	The law requires that the ite has been signed by th page 2 should be detache		9 ☐ Unknown Part II. Other significant conditions cor		ulting in the u	nderwing cause	given in Part I	23e Did	tobacco use con	tribute to th	he cause of de	eath?
ds,	signe d be o	Completed by	multilactor	Lanem		identying cadso	given in raiti		Yes 2□No		pably 4 □U	
Vital Records,	w requires been si should!	lete	Compresses	refraction	re/le	umb	as)	24a. Wa		Were auto	psy findings a	available
Re	The lay	omb	Oxteganos	ex Hope	tens	in C	excet	5 peri	ormed7	prior to cor death? 1 Yes	mpletion of ca 2 □ No	use of
/ital	ician: The lav certificate has rector, page 2	Be C	25. Was case refered to medical examiner?	10				e of Death (Check only				
of o	Physician: r this certifica ral director, I	To.	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien	T 3LI DOA		ursing Home 5 Res	how injury occur	1-77	y)	
O	tending Physician: The leath. Ior: After this certificate he the funeral director, page	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	1	njuryat Work? I □ Yes 2 □		Tiow injury occur	100		
Division	I or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, offi	се		(Street and Numb	oer or Rura	al Route Numb	70 <i>r</i> ,
ō	ital or A urs after ral Directled in by											
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 ✓ Certifying Physics (Check only one) 2 ☐ Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death tion and/or in	n occurred at th vestigation, in r	e time, date ar ny opinion, dea	nd place, and due to the ath occurred at the time	e cause(s) and ma , date and place,	anner as st and due to	tated. the cause(s)	
	with To 1	Σ	29b. Signature and title of certifier	•	()	29c. Lic	ense number	, ,	29d. Date signe	d (Month, i	Day, Year)	2./
7	5.		14 Kallett	essible	KKI.	D C	01/20	SI Albert	Veriem	her	2, de	34
	10		W. Name and address of person who co	mpleted cause of death (Iter	(Type,	CA-C	THERS	BULEG, M.	0 2081	ケク		
	Sta Registr		30. Name and address of person who con the ROBERT B (RS). 31. Date filed (Month, Day, Year) NOV 1 5 2004	3. Registrar's Signa	ture	NE S						

State of Maryland / Department of Health and Mental Hygien [] [] 35902 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** November 10,2004 4:30 p Catherine Η. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Village Care Center Parkville Baltimore 8. Date of Birth (Month, Day, Year) Feb. 21, 1913 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Yrs. 91 219-18-2819 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or itams 23s or 28e-1 show the Macked Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8800 Walther Blvd. 21234 LISA filed within 72 hours efter deeth Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other then College (1-4or 5+) Elementary/Secondary (0-12) Book Keeper Accounting 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event 9DGs. Be Samuel Hubbard Emma Rve 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9911 Fox Hill Road Perry Hall, Samuel Hubbard / Brother Md. 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cem. 11/13/04 ^¹ 4 □ Donation 5 □ Other (Specify) Dablin Southern Dublin, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. L icctions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be cause on each line. Immediate Cause (Final disease or condition resulting in death) emen **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the buriel-transit The law requires that the death certificate be executed that initiated events resulting in death) Last ed by the ettending physicien and detached for use as the buriel-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Dunknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of ause of death?

1 ☐ Yes 2 ☑ No 24a Wasan 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending investigation 2 Accident efter death Director: / the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours e To the Funerel C 29a. Certifier Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and ddress of person who completed vd, Parkville, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 15 2004 Registrar

State of Maryland / Department of Health and Mental Hygieney 35903 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey Year Physician 6. NOV 2337 5 Gun Zelmar nar 2004 1-6 10 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deel Examiner Hospita Baltimore If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Dey, Yeer) **Funeral** Days Hours Months 1 ☑ M 2 ☐ F Yrs Director 213-48-9688 Dec. 14,1948 <u>Maryland</u> Usuel Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiena. other than "naturel", or items 23a or 28s-4 show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantal Hygiena. Important: If item 27 is marked other than "naturel", or items 23a or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes AND Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 6452 Colonial Knoll 21061 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Status Black, White, etc. 1 Yes 2 □ No If Yes, Give 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: Vietnam White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Postal Service 12 Years Letter Carrier 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) å George Francis Gunzelman Laura Dembeck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Margaret L. Gunzelman/Wife 8192 Midhaven Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition *Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Veterans Cemetery 11/15/2004 Preston, Maryland 22. Name and Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature, of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine In necords, P.O. Box 68760, —
The law requires that the death certificate be executed signed by the attending physician and d be detached for usa as the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Tyes 2 No þ 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? is certificata has been si director, paga 2 should Completed 1 Tyes 2□No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funerel Director: After this combletely filled in by the funeral of 27. Manner of Death Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturel 1 🗌 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie edical 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number s of person who completed cause of deeth (Item 23a) (Type, Print) Sarahano Johns Hopkins Bayview M. C. 21224 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [] [35904 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9. 20Ó4 10:15 A <u>Kenneth H. Gegner</u> Nov. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lutherville Hearthomes at Lutherville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F Months Days Yrs Director 219-12-9682 80 26, 1924 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Items 23a or 28a-f shov 1 Yes 2 No Director Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2108 Forest Ridge Road 21093 USA by Funeral permit. Pages 1 and 2 should be filed within 72 hours after der Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "neturel", or Items any injury or other treumatic event, the Medical Exercise in once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ✓ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 res, Give Year or Dates: WWII 1 ☐ Yes 2 🛛 No Specify: Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Manufacturing Manager Western Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry 01ive 2 Gegner Amrhein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret Gegner/Wife 2108 Forest Ridge Rd. Timonium, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gardens Of Faith Cem. 11/13/04 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician preumonia week /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Causa (Disease or injur that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown osteaporosu Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 1 No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ass. 1 ☐ Yes 2 ☑ No 2 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 | Homicide within 24 hours a To the Funerel [1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier am 10.04 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 782 5 Road ork 07/2 32. Pegistrar's Signature 31. Date filed (MN) Pay Year) State Registrar

			For State Registrar	State of N	Maryland	d / Depa <i>Cei</i>	artmen rtificate	t of H	ealth a Death	and M		gieme ()	04	35905
			Decedent's Name (First, Middle, Last,)							2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		JOSEPH	HE	RR						NOV		2004	6:20A M
}	Examir		4a. Facility Name (If not institution, give	street and numbe	or)		4b. City,	Town, or	Location o	of Death		4c. Cour	nty of Deat	h
			GOOD SAMARITA	AN HO	SPIT	AL			10RE					
	Funeral		5. Social Security Number 6. Se	x 7.7	Age (In yrs. la		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 05/27/	h v, Year)	9. Birt	hplace (State or Foreign
	Director		215-28-5566	3 101 2 1	73	Yrs.					05/27/	1931		MD
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	danyl sho	ō	MD Anne Ari	ındəl	Pa	sade	na							1 □Yes 2 No
	28a-	rect	10e. Street and Number	anacı	1 4		10f. Zip	Code				10g. Citizen o	of What Co	l
	with 3a or	١	8543 Main Aven	10			2	1122)			U.S.	Α.	
	death ms 2;	era	11. Marital Status	12. Was Deceder		6. 13.				gin? (Spec	cify Yes or No- Rican, etc.)		ace - Ame	rican Indian,
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03	ral', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	S:		r tes	2)4) 190	эрөспу:			Spec	W	nite
21215-0036	within 72 hours after death with the Maryland ene. then "natural; or Items 23a or 28a-f show the Medicul Exartine from the Political at	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	tion u <i>ring mos</i> i	t of workin	ng	16b. Kind of	Business/	Industry
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	lled v Hygie her ti	ပိ	12 17. Father's Name (First, Middle, Last)			Sn	ippi				(First, Middle,			±
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Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "treumatic event, the Med	To	Joseph Herr 19a, Informant's Name/Relationship (Ty	rpe. Print)		19b. Mailir	na Address	(Street a			Route Numbe		m. State. Z	Zip Code)
Ma	ith an the street		Patricia Herr/		inlaw		•							
ō,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, I'm Medical Examin art must be notified at once.		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nan	ne of			ate	20c. Location		
Baltimore,	Pages nent of I int: If it		1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		te e	y Cr			'	11/1	6/04 H	Raltin	ore	. MD
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m	Depar Impor any ir		Tel to		-	1	69 R	ivie	era I	Driv	e, Pas	adena	a, MI	21122
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	e dea he att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant 9□Unknown		ath 5□	Other (sp	ecify)				,	Aonth	Day Year
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of	Phy rrthis eral d): To	27. Manner of Death	28a. Date of Ir	njury	28b. Time of		8c. Injury Work			8d. Describe h			
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	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifying Phy (Check only 2 Medical Exami											
	the H in 24 the F	Medical	опе)	and manner	stated.									
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,	(3)		30. Name and address of person who co						24	1	06 1	N= 1=	3 ~	
	Sta	ato.	GILBERT BOURTE 31. Date filed (Month, Day, Year)	32. Regis	syars Signati	ure ,	di .			IIMO	KE / M	WZ12	55	
	Registi		31. Date filed (Month, Day, Year)	004	zeneva	ير ر	1 4	Down	h					

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HAMER Month **Physician** Year November 12, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner POPLAR BAHIMORE Avenue 502 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 232-36-584 Yrs. Director 13, 921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at BAltimore 1 ☐ Yes 2 No by Funeral Director Mary Aud 1 10f. Zip Code 10g. Citizen of What Country? , or Items 23a or HVENUC 7502 21224 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene Important: If Item 27 Is marked other than "natural", or Itel Important: If Item 27 Is marked other than "natural", or Itel any joilury or other traumatic event, the Medical Examinas ADRS. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) tomemaker OWN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rosc MARIO JOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAUGHEN 10 VO 920b. Place of Disposition (Name of cometery, crematory or other place) SANDRA Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 □Removal from State AWN CEMETERY NOV 15, 2004 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Juneral Service Licensee 22. Name and Address of Facility JR. Fuverne Home 63 5- CONKING STRUCT 263 23a. Part1. Enterthe disease shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as calerac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEP SIS **Physician** GNE WER /Medical Due to (or as a consequence of): Examiner TWO WEEK OBSTRUCTION INTESTINAL Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 22No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Seridence 6 Other (Specify) Certification; To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA the funeral dir 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier to critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ths 29b. Signature and title of certified M.13: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 1.1) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 200 l 35907 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Denise Hodes November 3, 2004 10:45 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Riderwood Village Community Silver Spring Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months Min 1 ☐ M 2 🖳 F 147-34-6468 82 Director May 20,1922 France Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State traumatic avant, the Medical Examinar quart be notified at 1 ☐ Yes 2 X No Silver Spring Maryland Director Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 5 3128 Gracefield Rd. #621 20904 United States 238 Compieted by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 8 lack, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 21 No Specify. Specify: White 3K Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of 8usiness/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henri 0uéru Marie-Josephe Le Pennec Victor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health Itam 27 Laurent V. Hodes / Son 7418 Hancock Ave., Takoma Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ita any injury or ot once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Beltsville, MD Chesapeake Crematory | Nov. 5,2004 21. Signature of Fungral Service) 22. Name and Address of Facility
Rapp Funeral and Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD 20910 Approximate Interval 8etween Onset and Death Immediate Cause (Final Physician METASTANC YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 625 2081 Name and address of person who completed cause of death (Item 23a) (Type, Print) my HENDRICKS 410 ROCKLEDGE DR CAROLYN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 15 2004 Registrar

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	Funeral		5. Social Security Number	6. Sex			. last birthday)		If Under 24 Hrs.	8. Date of Birth (Month, Day,	n/a	Birthplace (State or Foreig Country)
	Director		214-22-9225		4 25CMF	78	Yrs.	Months Days	Hours Min.	July 29		Maryland
	/land		Usual Residence of Deceder 10a. State 10b. C			10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
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yland	be filed tal Hygi d other event, t	Be	17. Father's Name (First, M						18. Mother's Nam	e (First, Middle, M	faiden Sumam	9)
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a a	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Se	chla.	mai	1			ess of Facility Louens Ave. F			al Home Land 21229
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۲.	res that II igned by be detac	y Ph	Part II. Other significant co			-	-	Inderlying cause g	ven in Part I.	23e. Did tob	acco use contri	ibute to the cause of death?
SLas	w requires been sign should be	ed b	END STAG	****	NAC	Dise	FASE			1 □ Ye	s 2 No	3 Probably 4 Unknow
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<u>e</u>		e Cor	CONGESTI 25. Was case referred to m		CAR	DIAC	F41.	LURG	26 Plans of Dani		1	Yes 2000
=	Physicia this certi al directo	To Be	examiner?		spital: 1	npatient 2[☐ ER/Outpatie	nt 3□ DOA Ot	hor	ome 5 Reside		or (Specify)
n of	ing Ph Mer th uneral			Pending	28a. Date ((Mont	of Injury th, Day Year)	28b. Time o	Wo		28d. Describe ho	w injury occurre	ed
Division	of or Attending Patter death. Director: After I din by the funers	Certification:	3 ☐ Suicide 6 ☐	nvestigation Could not be determined	28e. Płace	of Injury - At	home, farm, st	M 1 []Yes 2□No			er or Rural Route Number,
2	tel or safter safter al Dire	Certi	4 Homicide		buildi	ng, etc. (Spec	cify)			City or Town	, State)	
	To the Hoepitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1 Ce (Check only 2 Me	rtifying Physic dicel Exemine	r: On the ba	best of my kr asis of examin ner stated.	nowledge, dear nation and/or in	th occurred at the to execution, in my	ime, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and mar ite and place, a	nner as stated. and due to the cause(s)
	within to the To the Comple	Med	29b. Signature and title of	ertifier	11	0.40		29c. Licen	se number	29	d. Date signed	(Month, Day, Year)
	i		· M	<u>~~~</u>	4	IMI		000	ORES	N	OVEMB	ER-07-200.
	P		30. Name and address of p	erson who com					BR STRE	ET RA	/_TIMAT	RE, MD 8128
	Sta		31. Date filed (Month, Day,	Year)		egistrar's Sigr			J.C 2 1100	, 0.76	- (1110)	-0 /. 10 000
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State of Maryland / Department of Health and Mental Hygiene 35909 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** KENNE NOVEMBER 7,2009 /Medical 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HIMORE N/A 7. Age (In yrs. last birthday) 57 Yrs. Year If Under 24 Hrs. 8. Date of Birth March 2ay, 1947 6. Sex 1 M 2 ☐ F 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours 214-44-3408 Mary Tand Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 289-1 show 77 is marked other than "natural", or iteme 23a or 28e-1 shov treumatic event, the Madical Examiner must be notified at Mary land N/A Baltimore 1XXYes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3340 Chesterfield Avenue 21213 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Ernest George Heyl Irene W. Graf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health item 27 i Irene W. Heyl/Mother 3340 Chesterfield Avenue Baltimore MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith 11/11/04 Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. Ruck, Inc. - 15305 Harford Road Baltimore Maryland 21214 Approximate Interval 8etween Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner PNEUMONIA 10 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 20 1445 CONTUSION LUNG law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ multiple vib tractures 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 No 2 No 1' Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No Certification; To this 28c. Injury at Work? funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural after death. 1900P M 1 Yes 2 No 2 Accident FELL DOWN STEPS 10/20/2004 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide AT 3340 CHESTERFIELD AVE BACTIMEREAD Home within 24 hours a To the Funerei C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 8,2004 RES-000 Missi BALTIMORE, MARYLAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL DRUMMOND 600 NORTH WOLFE STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 5 2004

State of Maryland / Department of Health and Mental Hygiene 00 14 1 - For State Registrar 35910 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{1}1$, **Physician** Month Fann D. Harvey November 2004 5:18 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Yes July 17, 1 Days Min. Hours 1 □ M 2 🖾 F Months 711-10-3925 84 Yrs. Director 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ehow 10d. Inside City Limits treumetic event, the Medical Examiner aust be notified at Director 1 ☐ Yes 2 No Maryland 28e-f Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 15101 Interlachen Drive 20906 or items 23e United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ρ Specify: 3 X Widowed 4 ☐ Divorced "neturel", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. ant: If I tem 27 le marked other then "n rry or other treumatin account. Elementary/Secondary (0-12) College (1-4or 5+) Secretary 4 Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank B. Downey Margueritte Danaher 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas D. Harvey/Son 4001 Montpelier Road, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State November 12, Department o Importent: If any injury or once. Montgomery 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2004 Crematorium, Inc. Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Pulmonary Disease Exacerbation 4 days Obstructive Chronic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Dual to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? filled in by the funeral director, page 2: autopsy performed? 1 Yes 2 No 1 Yes 2 No Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o 1 🔲 Yes Certification: To 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending Injury 1 Natural 5 Pending death. investigation 2 Accident 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D0060117 MD Nov 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric J. Park, MD 9901 Medical Center Drive, Reckville, MD 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2004 Sparit Registrar

ORIGINAL

HARUEY, FANA

State of Maryland / Department of Health and Mental Hygiene 004 35911

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			's Name (First, Mide									2. Dete of De Month		Yeer	3. Time of Death
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	Funeral Director		curity Number 8-4237	6. Sex 1 ☐ M 2		Age (In yrs. le 7	est birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir Apr 18	th 1917	9. Birthp Ma	olece (State or Foreign ntry)
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	a Manyler a-f show	10a. State Md	Wash	ington		10c. City	, Town or Lo Hager		n						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	ifier death with tha Mai r items 23s or 28s-f si rites must be notified	10e. Street 6	end Number N. Mulber	ry St.				10f. Zip	Code 1740				10g. Citizen of N USA	What Cour	ntry?
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Baltimore, Maryland	nd 2 should alth end N 27 is mer traumet	19a. Informa	ant's Name/Relation SSE M Wan			tor)							er, City or Town, wn, Md		
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æ	ne lav a has ige 2											10	Yes 2.10		☐Yes 2☐No
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	To the Hospital or Attanding Physician: The law within 24 hours aftar death. To the Funeral Director: Aftar this certificata has completaly filled in by the funeral director, page 2	29a. Certifie (Check one)	er 1 Certify only 2 Medica	I Examiner: O	To the best	of examinati	vledge, deatl ion end/or in	h occurred vestigation	et the ti	me, date an opinion, dea	d piece, a	and due to the ed at the time,	ceuse(s) and madate and place,	anner as s and due to	stated. o the cause(s)
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	State Registra		NOV 1 5		32. Regi	strer's Signat	ure doe	de						(

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Phys /Me	dical	Joseph A.	Kasak				NOV.	11, 20	70 8
Exar	niner	4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town,	or Location of Death		4c. County o	
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Funer Directe		212-09-1946	1 M 2 □ F	ge (In yrs. last birthda) 86 Yrs.	Months Days		8. Date of Birth (Month, Day	, Year)	Birthplece (State or Foreig Country)
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anylan ehow	_	10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
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al', o	þ	3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ If Yes, Give Year or Dates:	Nº Army WWTT	1 ☐ Yes 2 💢 No	Specify:		Specify:	white
I and 2 should be filed within 72 hours after death with the Maryland 1 Health and Mental Hygiene. I Health and Mental Hygiene. I them 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Mudical Examinations to notified an	Completed	15. Decedent's (Specify only highest of	Education	16a, Dec	edent's Usual Occu	pation	ina	16b. Kind of Busi	ness/industry
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and 2 sealth ar n 27 ls		Walter Kasak - n				ington Roa			
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그 된 뿐 등	900c	21. Signature of Funeral Service Lid	buch Cu	_ G	22. Name and Address	ess of Facility	eral Hom	ne @ Meado	owridge MP, Inc
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To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	one)	hysician: To the best miner: On the basis of and manner sta	examination and/or in	ivestigation, in my c	pinion, death occurre	ed at the time, da	te and place, and	due to the cause(s)
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Regis	tate trar	31. Date filed (Month, Day, Year) 15 2004	Alas es	B Ace	ريخ				50 1 8 07 U A

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	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Fulton C. Kracke 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) Months Days Hours Min. (Month, Day, Year) Warryland Usual Residence of Decedent	r Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. In Medical Examitter roust be notified at once.	To Be Completed by Funeral Director	906 Wilmington Ave. 21223 USA 11. Marital Status 1	2 No
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ecords, P	law requires as been sign 2 should be	ompleted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	known
n	ding Physician: Th. After this certificate funeral director, pag	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Namner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Natural 5 Pending 2 Accident investigation 29c. Injury at Work? M 1 Yes 2 No	
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the course (s) and means as a total	9 <i>F</i> ,
)	To the Ho within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 News and defined as stated.	004
41	ДD Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANA CEASAL, 960 SUTH CA7UW AVENUE BACTIMORE NO 2(25) 31. Date filed (Month, Pay, Year) NOV 1 5 2004 Separation	29
	Registr	ar	NUV I 3 2004 John John John John John John John John	

			1 - For State Registrar	State of Maryl	and / Dep		lealth and Mer Death	ntal Hygier	_	35914
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, I Helen Camilla A. Facility Name (If not institution, g	Kopicky		4b. City, Town, or		vember	Day Year 10 2004 4c. County of Deat	3. Time of Death 2:20 P.M.
	LAdillii	C!	Greater Baltimor		ter	Towson			Baltimore	
	Funeral Director		5. Social Security Number 219-30-2023 Usual Residence of Decedent	7. Age (In) 1 □ M 2 対 F 89	vrs. last birthday Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Ye. 4/14/19]	ar) 9. Birt Co 15 Pen	nplace (State or Foreign untry) nsylvania
	Marylend -1 show lied at	tor	10a. State 10b. County MD Balti		City, Town or L Hunt Va					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23e or 28e at be noti	al Director	10e. Street and Number 2 Chamaral Ct	•		10f. Zip Code 21(030	10g.	Citizen of What Co	untry?
936	filed within 72 hours after deeth with the Maryland Hygiane. ther than "natural", or Items 23e or 28e-f show ant, the Mccical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 22010No	ispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	Yes or No- in, etc.)	14. Race - Ame Black, White	
15-0	y within 72 hours piene. r then "netural", the Workel Ex-	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of working	16b	. Kind of Business/	Industry
Ind 212	be filed with tal Hygiene. d other ther event, the M	Be	12 17. Father's Name (First, Middle, La	st)	Но	omemaker	18. Mother's Name (Fi		Own Home	
Maryla	d 2 should th and Men 77 is marke treumatic	ည	Adolph Eberha 19a. Informant's Name/Relationship Joyce Burd				Kamilla I and Number or Rural Ro Hunt Vali	oute Number, Cit		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygison Importent: if Itam 27 is marked other thany injury or other treumatic event, that once.		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe	☐Removal from State	b. Place of Disp cemetery, cre hrist Lu	osition (Name of simatory or other place of the can Centre of the can Centre of the can be set to be set t	Date (Park) (Park)	20c.	Location - City or altimore,	Town, State Maryland
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Lic	Xagutt	•	415 Belai	ss of Facility Mille Ir Road Balt	imore,	el Funera Maryland	1 Home Inc. 21206
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the classifier of the cl	theu	iter the mode of dyin	g, such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of the cause of the	b. Due to (or as a con						/
3760,	ate be executed hysicien and he burial-transit	Ical Examiner	cause Theoder of fight that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):					
へ Division of Vital Records, P.O. Box 68	The law requires that the death certificate be executed tile has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12ymenths? 1 □ Yes 2 1 ■ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
rds, P	quires that n signed b	by P	Part II. Other significant conditions	s contributing to death but not	_	underlying cause give	en in Part I.			the cause of death?
I Reco	The law requir	Completed	Remember	/				24a. Was an autopsy performed 1 Yes 2	prior to c	copsy findings available completion of cause of
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		other scanners of	26. Place of Death (Cf	neck only one)		
ion of	ng Ph Ifter th	tlon: To	1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	of 28c. Injury Worl	4 Nursing Home	5 Residence Describe how in		ify)
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could not determine	28e. Place of Injury - A building, etc. (Sp	At home, farm, si ecify)	treet, factory, office	28f.	Location (Street City or Town, St.	and Number or Ru ate)	ral Route Number,
	in 24 hour in 24 hour the Funer pletely filli	edical	29a. Certifier 1 Certifying 2 Medicel Ex	Physician: To the best of my eminer: On the basis of exan and manner stated.	knowledge, dea nination and/or i	th occurred at the tin ovestigation, in my of	ne, date and place, and opinion, death occurred a	t the time, date a	and place, and due	to the cause(s)
	í	W	29b. Signature and title of certifier	ralym		D30	9 number) 433	NO	Date signed (Month	D4, Year)
	V		30. Name and address of person when M MM M N	completed cause of death (Item 23a) (Type	N CHARL	E(57	BALT IM	DRE N	1021204
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	bout.				

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of ertificate of		nd Mental Hy	giene 0	04	3591	5
	Physic /Medi		1. Decedent's Name (First, Middle, Last, Carl H.	Livesay			C	2. Date of De Month Novemb	aath Day	Year 2004	3. Time of Dea	ath M
	Examir		4a. Facility Name (If not institution, give 1738 Arrington Ro	ad		Marr	or Location of D	Death		y of Death	10.43p	
	Funeral Director		5. Social Security Number 6. Set 226-38-4854 17	7. Age	e (In yrs. last birthday, Yrs.	Months Day		Hrs. 8. Date of Bir Min. (Month, Da Nov 13	v. Year)	9. Birthp Coun TN	lace (State or Fo	reign
	Maryland a-f show	ctor	10a. State 10b. County Md Carroll		10c. City, Town or L Marric	ocation ottsville	9			1	0d. Inside City Li	
	th with the 23a or 28	Funeral Director	10e. Street and Number 1738 Arrington Ro	ad		10f. Zip Code 21104	+		10g. Citizen of USA	What Coun	try?	
980	a within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at	þ	11. Marital Status 1 ☐ Never Married ② Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Types 2 N If Yes, Give Year or Dates:	∘ 1955	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ W	ban, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	Bla	ce - Americ ck, White,	etc.	
Maryland 21215-0036	within ane. than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5 +2	+) (Give	dent's Usual Occi kind of work don DO NOT use retir	a during most of	working	16b. Kind of B	usiness/Ind	lustry	
yland	should be filed and Mental Hygiet marked ather umatic event, I	To Be (17. Father's Name (First, Middle, Last) Dewey Livesay				Addie	Name (First, Middle, Mary Col	lingswo	rth		
e, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumatic e once.		19a. Informant's Name/Relationship (Ty, Marjorie Livesay (1738	Arringto	on Rd.,	Marriotts	ville, N	Md 21	104	
Baltimore,	it. Pages rtment of h rtant: If ite njury or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		Lake View	matory or other pl Memoria	1 11	-12-04	Sykesv	ille,	Md	
Ba	Dermi Depa Impo		21. Signature of Funeral Service License Puge Hought 94 23a. Part. Enter the disease, or compli	ubert	P	.0. Box	195 Syk	Haight Furesville, l	Md 21784	ome &		
	Cate be executed //Medical Examiner the burial-transit the burial-transit	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	Cours	ing, such as can	ulac or respiratory ar	rest,		Approximate Interval Between Onset and Death The Way Way	h
Box 6	death certifi e attending d for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 10 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	cy		23d. Dat	te of deliver	y Day Year	
S,	sign sign d be		Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	nderlying cause g	ven in Part I.	23e. Did to	,		e cause of death	
		Completed						24a. Was a autop perfor 1 \(\subseteq \text{ Yes} \)	med?	rior to com leath?	sy findings availa pletion of cause	able of
Division of Vit	ding Ph h. After th funeral	atlon; To Be	27. Manner of Death 1 Dratural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time of	28c. Inju	her: 4 🗆 Nursin	Death (Check only on g Home 5 A Resid 28d. Describe h	ence 6 Othe	er <i>(Specify)</i> ed		
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	To the Hospital or A within 24 hours after To the Funerel Direc completely filled in by	ledical	one)	ician: To the best of er: On the basis of and manner state	my knowledge, death examination and/or invest.	occurred at the ti restigation, in my	me, date and pla opinion, death o	ace, and due to the c courred at the time, o	ause(s) and mai late and place, a	nner as sta ind due to t	ed. he cause(s)	
•	./	×	29b. Signature and little of contifier at little to the	Sus		29c. Licen:		2	29d. Date signed	1 (Month, D.	ay, Year)	
	12		30. Name and address of person who cor	mpleted cause of de	ath (Item 23a) (Type, 1	Print)		DOBBURT W	D 21:	784		
	Sta Registra		31. Date filed (Month, Day, Year) NOV 1 5 2004	32. Registrar	s Signature	de						

		•	For State Registrar	Sta	ite of M	1arylan		artment			and M	lental H	-	2111) 4	359	16
			negistrar Decedent's Name (First, Middle	Last)				imoute	0, 2	Journ		2, Date of I	Reg. I	10.		3. Time of	f Death
	Physici		Mildred Clusm	an L	arkin	3						Month Novem	ber	12.	2004	7:55	nm M
	/Medio Examir		4a. Facility Name (If not institution,		and number	r)		4b. City,	Fown, or	Location o	f Death			4c. County			P
1			Greater Baltim	ore Me	edical	Cent	er	Tows	on]	Balti	more		
	Funeral		5. Social Security Number	6. Sex			ast birthday)	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of E	lirth Da <i>y, Ye</i> a	ar)	Coun	lace (State o	or Foreign
	Director		215-42-8073	1□ M 2	X.	83	Yrs.		,			June 1	9,	1921	Mary	/land	
	land		Usual Residence of Decedent 10a. State 10b. County			10c. City	, Town or Lo	cation							1	0d. Inside Ci	ity Limits
	Mary -1 sh	ţ	MD Balti	more		Tou	JSON									1 🗌 Yes	2 No
	r 288	lrec	10e. Street and Number			1.00		10f. Zip	Code				10g. (Citizen of	What Coun	try?	
	th wit	ai D	1055 West Joppa	Road				212	204				Uı	nited	! Stat	es	
Maryland 21215-0036	toges 1 and 2 should be filed within 72 hours after deeth with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Executing to the fraumatic smission of the first transmission	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	ad 1 [as Decedented Forces Yes 20 Yes, Give tar or Dates]No		Was Deced if Yes, spec 1 Pes 2	V	spanic Orig n, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or t Rican, etc.)	10-	Bla	ck, White, c y: White,	etc.	
20	72 ho	ted	15. Decedent (Specify only highes		nleted)		16a. Dece	dent's Usua	l Occupa	ation	of work	na	16b.	Kind of B	usiness/Inc	lustry	
21	ithin 7	Completed	Elementary/Secondary (0-12)	Co	llege (1-40	5+)	_	kind of wor DO NOT us	e retired,)	OF WORK	ng		- (
12	led w lygier her th		47 F. H. J. N (F) At 11		5+		108	acher		45.14.45		(=)			catio	<u>n</u>	
ano	12 should be filed within in and Mental Hygiene. The marked other than "reumatic event, the Mental Mental In a Men	Be	17. Father's Name (First, Middle, L John Henry Clus							Susa		e (First, Midd Lussell		en Suman	ne)		
ڇّ	hould d Mer mark	ဥ	19a, Informant's Name/Relationsh		iatl		10b Mailie	a Addross	(Stroot a			I Route Num		. or Tour	Ctata 7i-	Cadal	
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	permit. Pages 1 and 2 Department of Health a Important: If item 27 to any injury or other tra once.		20a. Method of Disposition	.K/ 484	gireci	20b. P	ace of Dispo	sition (Nam	e of	1		Date	,		City or To		
Baltimore,	Pages nent of int: if it		1 X Burial 2 ☐ Cremation 4 ☐ Dogation 5 ☐ Other (Sp		al from State		emetery, crer int 01:				11/1	6/2004			more,		
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B	permit. Departr Imports any inju		saylat (1 St		Coste	er 10	050 Yo	ork l	Road,	Τοω	son, M	1D 2	21204			
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	uted Insit	min	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury			estiv	1	teart	. 1	Fail	1 re				ò	Lwee	hs
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Ξ	Physician: this certificatal director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospita	l: . rel		FB/0		Othe			(Check only					-
of	Phys r this aral dii	-	27. Manner of Death	28a	. Date of In (Month, D		ER/Outpatien 28b. Time of		Bc. Injury	at		ne 5 Res 28d. Describe					
ion	nding I th. :: After e funer	ation	1 Natural 5 Pending 2 Accident investig		(Month, D	ay Year)	Injury	М	Work 1 □ Y	? ′es 2 □ N	10						
Vis.	Atter r dea ector by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		. Place of Ir	njury - At ho	me, tarm, str	eet, factory,	office		1	28t. Location	(Street a	and Numb	er or Rural	Route Num	ber,
Ö	s afte	Sert	4 Hornicide		building, e	etc. (Specify)					City or T	own, sta	10)			
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier 1 Certifying (Check only one)	.xaminer: O	To the bes	of examinat	wledge, death ion and/or inv	occurred a restigation,	it the tim in my op	e, date and inion, deat	place, a	and due to the	e cause(, date a	s) and ma nd place,	nner as sta and due to	ted. the cause(s)
	Nithin Fo the	Me	29b. Signature and title of certifier					29c.	License	number			29d. D	ate signe	d (Month, E	ay, Year)	
	_		Willi W	74	n Cos	ne	M	1	Ju	1210	29		No	V. 1	3, 2	004	
	10		30. Name and address of person v	A	ed cause of		23a) (Type,	N. CI	heri	les S	54	Bal+					212
	° Sta	te	31. Date filed (Month, Pay, Year)	nna	,	trar's Signal		100	1	/							
	Registr	ar	1101 # 0 6	705	of the		1	L'ace	100 to 100								

State of Maryland / Department of Health and Mental Hygien & O. I.

1. Decedent's Name (First, Middle, Last) 2. Date of Death Morth Day Year Middle, Last) 1. Decedent's Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle, Mailer Surame) 1. Decedent Name (First, Middle,				1 - State Registrar		- · · · · · · · · · · · · · · · · · · ·	Ce	rtificate of	Death	Wichita i i			3591
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Exemption of a Facility Name of Procession Company of Name and Procession Company of Name of N				John Joseph I	afayette								1.50 pm
South Security Number Size Security Number Security Number Size Security Number Size Security Number				4a. Facility Name (If not institu	tion, give street and n	umber)		4b. City, Town,	or Location of Dea				
Social services of Department Social Services of Departmen					-						Ва	altimore	
Control of the cont				5. Social Security Number	-	7. Age (In yr					Day Year nber 11, 2004 1:50 pm 4c. County of Death Baltimore Birth Baltimore Birth Country 9. Birthplace (State or For Country) 5, 1928 New York 10d. Inside City Lin 1 Yes 2 1 1 1 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lace (State or Foreig	
Total State 100 County 100 City Town or Location 1		Director			1		76 Yrs.			May 1			
17. Father's Name (Pists, Middle, Last)		land			nty	10c. C	City, Town or L	ocation				11	Od Inside City Limit
17. Father's Name (Pists, Middle, Last)		Mary	ò	MD	C 1								
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17. Father's Name (Pists, Middle, Last)		3a or	0	3500 P1- P '							-		
17. Father's Name (Pists, Middle, Last)		The 2	era		12. Was Dec	cedent Ever in	U.S. 13.		Hispanic Origin? (Specify Yes or N	Uni		
17. Father's Name (Pists, Middle, Last)	•	or Itan	Ē		larried 1 ☐ Yes	2 50 No				rto Rican, etc.)			
17. Father's Name (Pists, Middle, Last)		al', d	by		l If Yes. G	ive Dates:		1 ☐ Yes 2 🗷 No	Specify:				
17. Father's Name (Pists, Middle, Last)	2000	72 ho	ted	15. Deced	lent's Education	1	16a. Dece	dent's Usual Occup	pation		16b. Ki		
17. Father's Name (Pists, Middle, Last)		thin	nple				life.	DO NOT use retire	during most of wi	orking	Pub	lic Safet	.y
21. Signature of Turner (Speechy) 22. Name and address of Faciny Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimor Modicial Examinor Physician Examino	1	ygien ygien t, th	Con				Firen	nan					
21. Signature of Turner (Speechy) 22. Name and address of Faciny Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimor Modicial Examinor Physician Examino		d oth	Be	17. Father's Name (First, Midd	le, Last)				18. Mother's Na	me (First, Middl	e, Maiden	Sumame)	
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1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature 32b. Injury at Work? 1 Yes 2 No 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 32. Registrar's Signature 32b. Injury at Work? 1 Yes 2 No 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 32. Registrar's Signature 32b. Injury at Work? 1 Yes 2 No 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed (Month, Day, Year) 29d. Date filed		yaici s cer direci	0	examiner?	Haspitals	Inpatient 2	TER/Outnation	3 DOA Oth				MO Other (Conside)	HOGDTON
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			100	NOV 1 5 200	32. R	egistrar's Sign		ę.					

1:50 p.m.

NOVEMBER 11, 2004

JOHN LAFAYETTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fh 9837 11-19-04 vt.
State of Maryland? Department of Health and Mental Hygiene

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinat must be untilled at acres. Outce.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1 - State Registrar		Cer	tificate of l	Death		Reg	1. No. 2	1 U 4	35918
1. Decedent's Name (First, Middle	le, Last)				2. Date Mor	of Death	Day	Year	3. Time of Death
	Martha	M. Looper				mber	-	2004	6:50a M
4a. Facility Name (If not institution			4b. City, Town, or	Location o			4c. Count		0.500
National Luther	ran Home		Roc	kvil	1 e		Мо	ntgom	erv
5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8 Date	of Birth	1000	9. Birthp	lace (State or Foreign
577-03-1271	1 ☐ M 2 🛣 F	95 Yrs.	Months Days	Hours	Min. Sept	ith, Zaz	1909	Man Man	ryland
Usual Residence of Decedent	1	75			1500		1707	11d1	Lyzand
10a. State 10b. County	,	10c. City, Town or Loc	cation					11	0d. Inside City Limits
Maryland Mont	tgomerv	Clarksbur	~						1 ☐ Yes 2🏞 No
10e. Street and Number	Lgomery	CIALKSDUL	10f. Zip Code			100	. Citizen of	What Coun	ntry?
26201 Rudale Di		10.		0871	-:-2.40#		Jnited	Stat	
11. Marital Status	12. Was Deceden Armed Forces	? If	Vas Decedent of Hi Yes, specify Cuba	n, Mexican	gin? (Specify 1 es i, Puerto Rican, e	tc.)		ick, White,	
1 Never Married 2 Mar	If Yes, Give	1	☐Yes 2⊠No	Specify:			Specif	y:	• •
3 XWidowed 4 ☐ Divorced									nite
15. Deceder (Specify only highe	nt's Education est grade completed)	(Give I	ent's Usual Occupa kind of work done o	luring most	t of working	16	8b. Kind of B	usiness/Ind	dustry
Elementary/Secondary (0-12)	College (1-4or	5+)	OO NOT use retired)					
	1	S	ecretary				Law F		
17. Father's Name (First, Middle,	Last)			18. Mothe	r's Name <i>(First, I</i>	Middle, Ma	iden Sumai	πe)	
George Mills				Eliza	abeth An	n Oal	cman		
19a. Informant's Name/Relations	ship (Type, Print)	19b. Mailin	g Address (Street a					, State, Zip	Code)
Ora Shoemaker/	Daughter	26201	Rudale I	rive	Clarksh	1110	Maru1	and	20871
20a. Method of Disposition	Daugittet	20b. Place of Dispos cemetery, crem	sition (Name of	LIVE	Date		c. Location		
1 ⊠Burial 2 □ Cremation		9			11/1/10			,	
*4 □ Donation 5 □ Other (S		Parklawn 1				4 R	ockvi.	lle, l	Maryland
21. Signature of Furteral Service	Licensee		. Name and Addres			- Fur	eral	Home	
1 Sall	Minu	26	401 Ridge	Road	l, Damas	cus,	aryla	nd 20	872
23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cause	ed the death. Do not ente	or the mode of dyin	g, such as	cardiac or respira	atory arres	t,		Approximate Interval Between
Immediate Cause (Final	Con	-0 basis	9000	lan	dias	110		7	Onset and Death
disease or condition resulting in death)	a	s a consequence of):	accio	a I	ine	24		- 4	jews
	Die to (or a	s a consequence oi).	o Na	1	merse	dem	enk &	R.	Veane
Sequentially list conditions,	b. Out to loca	s a consequence of):	Mig	jul	whe i			_/	
if any, leading to immediate cause. Enter Underlying	4	a consequence on.	200 5	La	· Hen	1			111 1.
Cause (Disease or injury that initiated events resulting in death) Last	c	010/08	eer)	1-	101000				Nowin
rosaling in dodiny East	Due to (or a	s a consequence of)[/							
	d								
IS ECHALS.									
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ectopic pregnancy					ate of delive	,
in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnant		Other (specify)				Mo	onth	Day Year
9 Unknown	9□ Unknown								
Part II. Other significant condit	ions contributing to death	but not resulting in the un	derlying ceuse give	en in Part I.	236	. Did toba	cco use con	tribute to th	ne cause of death?
18 100	ust co	encer				1 🗆 Yes	2 Abo	3 Prob	ably 4 □Unknown
100 000	VI (
					24a	. Was an autopsy		prior to con	psy findings available npletion of cause of
					10	performe	d?	death?	2 □ No
25. Was case referred to medica	al			26. Place	of Death (Check				
examiner?	Hospital: 1 _ Inpat	tient 2 ER/Outpatien	t 3 DOA Othe	25	rsing Home 5		ca 6 000	nor (Specif	4)
27. Manner of Death	28a. Date of in						injury occur		"
1 ☑Natural 5 ☐ Pendi	ing (Month, D		28c. Injun Work	k? Yes 2 ∐i			, , , , , , , , , , , , , , , , , , , ,		
2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	tigation			. 63 2 🔲		ation (a)	-1	h	10-1-11
	mined 286. Place of I	njury - At home, farm, stre etc. <i>(Specify)</i>	et, factory, office			ation (Stre or Town,		oer or Rura	l Route Number,
							111		
	ing Physician: To the bes								
(Check only 2 Medical one)	I Examiner: On the basis and manners		ostigation, in my of	THORI, GBA	occurred at the	mie, dat	and place,	ariu due to	uie cause(s)
29b. Signature and title of certific	er 1		29c License	number		29	l. Date signe	d (Month, L	Day, Year)
1 day lu	10 16	1 11	112	172	1	11	men	sen	11,2004
- Coeca	vo janen) 100	1/0		, ,			1//
30. Name and address of persor									
Charles W. Kar	esh M.D. 260	U33 Ridge Ro	oad, Dama	scus,	_Marylar	nd 20	872		
Charles W. Kar	2004 32 degis	strar's Signature							
	2004	w & for	and I						
			A						

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Items 27 28a7 bearinger of Health and Methal Hygiere of Item 28d per ME, G837, 11/15/1/20/2016 beath

	1	- State Amend Item 28d per ME, G837, 11, 15, 12004 dbb Death		Reg. No.	14 35919
Physicia		Decedent's Name (First, Middle, Last)	2. Date of D Month	eath Day	Year 1820 M
/Medica	al -	John Edward Lample 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deatl	201		y of Death
Examine	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deatl 4c. City, Town, or Location of Deatl	5	40. 00011	N/A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, D	irth Day, Year)	Birthplace (State or Foreign Country)
Director		214-92-4823 XXM 2 F 41 Yrs. Months Days Hours Min.	Jun. 1	3, 1963	Maryland
yland	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
e Man	ctor	MD Howard Elkridge		,	1 ☐ Yes 2√ No
with th	ۃ	10e. Street and Number 10f. Zip Code 21075			What Country? States
death v	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (S	pecify Yes or N		ice - American Indian,
030 urs a	2	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No Specify: 1 Yes 2 No Specify:	to Hican, etc.)	Speci	ack, White, etc. ify: White
15-0	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work file. DO NOT use retired)	rking	16b. Kind of 8	Business/Industry
withir iene.	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Stationary Enginee		М	echnical
e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middl	e, Maiden Suma	me)
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	2	George Lample Alice			
Mar 12 sh 12 sh 7 is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru			
re, l Healt Healt tem 2		Dorothy Lample Wife 6711 Burnbridge Hunt 20a. Method of Disposition (Name of cemetery, crematory or other place)	Date		- City or Town, State
Pages nent of int: If in	1	1 XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 9-18	3-2004	Baltim	ore, MD
Baltimore, oermit. Pages 1 ar Department of Hee Important: If item any injury or other page.	(Agriculte of mara server the server than 22. Name and Address of FacilityAmb			•
m goesa	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			
		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Curbon Monaxide Anderse disease or condition Curbon Monaxide Anderse disease or condition Curbon Monaxide Anderse disease or condition Curbon Monaxide Anderse disease or condition Curbon Monaxide Anderse disease di	1		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	POXI	Cutib	n I hour
Examiner		Sequentially list conditions b.	\sim	111	
g 5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	1	Valor	
68760, tilicate be executed by physician and as the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):	NA		
	Medical	d	A COURT	VAMINER	
		IF FEMALE:	E SY MED.		
S, P.O. Box igned by the attendi	Physician/	23b. Was decedent pregnant in the past 12 months?		23d. D	ate of delivery Ionth Day Year
Co the ached	hysi	1 Yes 2 No 9 Unknown			
S, P	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ntribute to the cause of death?
Sords, v requires the sign should be			-	Yes 2 No	3 Probably 4 Unknown
2 2 2 2	Completed		24a. Wa auto per	opsy formed?	. Were autopsy findings available prior to completion of cause of death?
Vital Reulclan: The law certificate has	a	25. Was case referred to medical 26. Place of De.	1 ☐ Yes ath (Check only		1 ☐ Yes 2 ☐ No
of Vita Physician: this certific	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Hospital:		sidence 6 🗆 O	her (Specify)
On O		27. Manner of Death 1 □ Natural 5 □ Pending		how injury occu	lawn tractor
Division To Attending after death. Director: After	icati	2 Accident investigation of the could not be determined determined. 2 Notice of the could not be determined.	28f. Location	(Street and Num	t fumes from automber or Rural Route Number,
Div Div after a libire	Certification:	4 Homicide building, etc. (Specify)	City or Te	own, State)	e Hunt Ct. Md.
Division of Vital Re To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate hi completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the	e cause(s) and m e, date and place	nanner as stated. , and due to the cause(s)
Total	Σ	29b. Signature and title of centifier 29c. License number 29c. License number 29c. Discusse number 29c. Di	5	Septem	ed (Month, Day, Year) De 13, 2004
10		30. Name and address of person and completed cause of death (Item 23a) (Type, Print) M. L. Friden bottom of the Stanes H	2154	1 13,	De 13, 2004 al Hornore MX
Sta	te	3 1	sh. of	1 1 1 4	LUI VIVIII
Registra		NOV 0 9 2004 Server Signature			

BLANCA	MARIA	LOI	PEZ_BUSTIL							_		_	le.	
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	Physic /Medi		Decedent's Name	Blanca	Maria Lo		ıstill)		Mor	of Death			ne of Death
	Exami	ner			ve street and numbe	er)		4b. City, Town,	or Location of D	eath		4c. County of		J
00			5 OLD CLU 5. Social Security N		Sex 7	Ane (In vrs	last birthday)	ROCKVII		Hre o D-4-		10NTGOM		
159	Funeral Director		217-82-88	383	1□M 2⊠F	44	Yrs.	Months Days		Min. Sept	of Birth oth, Day, Ye	960 s	Birthplace (St. Country) Illinoi	_
3	ow other		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Insid	de City Limits
	death with the Maryland ms 23a or 28a-f ahow rmust be rodified at	ctor	Maryland	Montgon	nery			Rockvil1	e					Yes 2⊠No
	with th	Director	10e. Street and Nur					10f. Zip Code			10g.	Citizen of Wha	at Country?	
	leath ns 23	Funerai	11. Marital Status	lub Court	12. Was Decede	nt Ever in II	S 13		0852) (Casaib. Va-		nited S		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Heatth and Mental Hygiene. Important: If itam 27 ia markad othar than "natural", or frams 23a or 28a-1 ahow any injury or other traumatic evant, the Medical Examinat must be notified at 200e.			ied 2□ Married	Armed Force 1 ☐ Yes 2 5 If Yes, Give	s?		Was Decedent of If Yes, specify Cul				Black,	American India White, etc.	n,
21215-0036	hours tural',	d by	3 Widowed		Year or Dates	s:		1⊠Yes 2□No	Б Брөспу:	onduran	L y	Specify:	White	
7.	in 72 n "nal	Completed		15. Decedent's E	ade completed)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most of i ed)	working	16b	. Kind of Busir	ness/Industry	
212	ad with	Com	Elementary/Secon	ndary (0-12)	College (1-4o	or 5+)		vel Ager				Trave	1	
Maryland	be file tal Hy d oth	Be	17. Father's Name (18. Mother's f	Name (First, A	Aiddle, Maid	den Sumame)		
<u>5</u>	d Men narka natic	^C		pez-Rive						iqueta				
Ma	nd 2 sl Ith an 27 ia r traur		19a. Informant's Na Ramon Lop					ng Address (Stree Club Co						
re,	of Healitam		20a. Method of Disp	position		20b. P	Place of Dispo	sition (Name of natory or other pla	,	Date	20c		y or Town, State	
Baltimore,	Page ment c ant: If ury or				□Removal from Stat fy)	" Mor	ıtgomeı	ium, Inc	NOV	ember 1 2004	l3, Bet	hesda,	Mary1a	nd
Balt	permit. Depart Import any inj once.		21. Signature of Fu	neral Service Lice	nsee		RO	Name and Addr	ess of Facility	y Funei	cal Uc	Bet	hesda-C	hevy
	40240		23a, Part1, Enter th	ne disease, or com	polications that caus	M001	15.	WISCOU	SIN Ave.	, Betne	sda, I	MD 2081	4-3501	
	Pnysician		Immediate Cause (Final	pplications that cause one cause on each						tory arrest,			Between nd Death
	/Medical		disease or condition resulting in death)	•		Land as a consequ		ne Intox	cication					
	Examiner	L	Sequentially list con if any, leading to im	nditions,	b								5	
at	rted nsit	Examiner	Cause (Disease or i	College Co.	Due to (or a	is a consequ	uence of):							
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9289	ate be hysicia ihe bu	ledicai			d									
99 ×	death certificate t attending physion	/Med	IF FEMALE:		23c. If yes, outcom	-								
Вох	death of attended for up	ician/M	23b. Was decedent in the past 12 t 1 \(\text{Yes} \) 2 \(\text{L} \)	months?	1☐Live birth	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of Month	delivery Day	Year
P.O.	requires that the death certificate een signed by the attending phys hould be detached for use as the	Physi	9 🗆 Unknown		9□ Unknown			,,,,,,						
	res tha signed be de	by	Part II. Other signifi		contributing to death	but not resu	ulting in the ur	derlying cause gr	ven in Part I.				e to the cause of	of death?
ecords,	w require been sig should b	eted	Cocaine U	Jse						-	1 Tes	2 □ No 3 □	Probably 4	Unknown
Rec	e lav has je 2	ompieted								-	Was an autopsy performed?	prior	autopsy finding to completion of	gs available of cause of
(2) Ista		e C	25. Was case referre	ed to medical					26. Place of D	11	res 2 n		res 2□No	
o	si si	To B	examiner? 1XXX es 2 □ 1	No	Hospital: 1 ☐ Inpat	tient 2 🗆 I	ER/Outpatient	3□ DOA Ott				6 □Other (S	Specify)	The state of
	ding Ph h. After th funeral		27. Manner of Death 1 ☐ Natural	5 Pending	Fourndh, D		28b. Time of Found	28c. Injui Wor	ry at			ury occurred		
Division	deatl	ertification:	2 Accident 3 Suicide	investigation	11-8-04		7:30	A	Yes 2 No	Unkno				
Div	i Diff o	0	4 Homicide	determined	Found a	it hom	e	et, factory, office		Rocky	rTown, Sta rille,	^{t⊕)} 5 O1d Md	Rural Route No Club (Jourt Court
	To the Hospital within 24 hours a To the Funaral Completely filled	edical	29a. Certifier (Check only one)	Certifying Ph	ysician: To the bes niner: On the basis and manner s	or examinat	viedge, death ion and/or inv	occurred at the tire estigation, in my o	me, date and pla ppinion, death oc	ce, and due to curred at the t	the cause ime, date a	s) and manner nd place, and	as stated. due to the cause	B(S)
	To the within 2 To tha complet	Me	29b. Signatore and t	itle of certifier		00	7	29c. Licens			29d. D	ate signed (Me	onth, Day, Year)
	V. S.		tet	- ll	smile-	Toll	She N	S OCT	Æ		NOV	EMBER 9	, 2004	
	16 Jay		30 Name and addre	ss of person who	completed cause of	death (Item	23a) (Type, F	reet, Ba	altimom	Maw-	land.	21202		
	Sta	te	31. Date filed (Month	n, Day, Year)	32. Regist	trar's Signat		ace, De	T CHINT C	, raty	Talia '	21201		
	Registra		NU	v 1 5 2004	1 Wales	· It	Len	w						

BILLY	RAY MA	RT	IN For - State Registrar	State of Maryland		rtment of H		ental Hygie	ne 2004	35921
	Physicia /Medic	n	1. Decedent's Name (First, Middle, Las	" MARTIN, J	TR.			2. Date of Death Month NOV . 7	Day 2004 Year	3. Time of Death 0447 A M
	Examine	er	4a. Facility Name (If not institution, give UNIVERSITY HOSPI	TAL		BALTIMO	Location of Death		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sec 433 - 39 - 4333 7 Usual Residence of Decedent	m	st birthday) 28 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth Con	nplace (State or Foreign unity) LA
	Maryland if ehow		10a. State 10b. County MD RALTIN		Town or Loc	ation 2 MILL				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23e or 28a st be noti	Funeral Director	10e. Street and Number Le DUKE DF WIN	DSORCT. APT.	T4	10f. Zip Code	1207	10g.	Citizen of What Cou	,
936	72 hours after death with the Maryland natural; or Items 23e or 28e-f show alcal Examiner must be nutified at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ★Yes 2 No If Yes, Give Year or Dates:	ł	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: BL	, etc.
altimore, Maryland 21215-0036	c	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decede (Give k life. D	ont's Usual Occupa ind of work done of O NOT use retired,	fu <i>ring most of workir</i>)	ng 161	D. Kind of Business/li	,
yland 2	Mental Hyg arked othe atic event,	To Be Co	17. Father's Name (First, Middle, Last)	ETIN, SR.		THE STATE OF THE S	18. Mother's Name			
e, Mar	is 1 and 2 sho of Health and item 27 is my other treumy	_	19a. Informant's Name/Relationship (7 SYBIL MARTIN	/MOTHER	705	7 Mc CLE	CAN BU	ID. PARI		ID 21234
timor	permit. Pages 1 a Department of Hes Importent: If item any injury or othe once.	6	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,	Removal from State	GREE	tion (Name of atory or other place VM DUN	11.16	-04 1	3ALTIMO	
Ba	Depa Impo		21. Signature of Funeral Service Licens 2 august 1 23a. Part1. Enterthed issease, or comp about or head failure. I st only a	2//	5	51 BALT	got Facility IMDRE NA	TU PIKE	BALTO. M	
	nysician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.			wound		ad	Approximate Interval Between Onset and Death
E	Examiner	Exa	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as a conseque c. Due to for as a conseque d.						
Division of Vital Records, P.O. Box 68760,	igned by the attending probe detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	éath 3 □E	ctopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
rds, P	been signed t	ò	Part II. Other significant conditions co	ntributing to death but not result	ing in the und	erlying cause give	n in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
al Reco	certificate has been rector, page 2 should	Completed	100					24a. Was an autopsy performed	? prior to co	opsy findings available impletion of cause of
of Vii	After this certifuneral directo	0	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death		P/Outpatient 8b. Time of		4 Nursing Hom		6 Other (Specia	iy)
ivision	within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day Year) - Q - O - At hom building, etc. (Specify)	O7:2	28c. Injury Work 1 □ Y	es 2 No	subject	and umber or Rura	er N Route Number
O	within 24 hours after To the Funerel Directory completely filled in by		(Chack only SX KMenical Exami	sician: To the best of my knowle	edge, death o	occurred at the time	a date and place, as	3 Chancel	e Cons	y MO
	within 2 To the complet		one) 29b. Signature and title of certifier	and manner stated.		29c. License		29d.	Date signed (Month,	Day, Year)
É			30. Name and address of person who co	ompleted cause of death (Item 2			Baltimor	e, Maryla	and 21201	
1	State Registra	-	31. Date filed (Month, Day, Year) NOV 1 5 2004	32. Registrar's Signatur		boulst				

State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Juliette 11 2004 /Medical 5:00 a. Marcus 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Villa St Michael N/H Balto 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.
Months Days Hours Min. **Funeral** Birthplace (State or Foreign Country)
 C Date of Birth (Month, Day, Year) Months 043-22-2679 1 M 200 Director S.C. 10-8-1923 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Count 28a-f show 10d. Inside City Limits traumatic event, the Medical Expedient must be notified at Director 1 XYes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or items 23a 4800 Seton Drive 21215 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---" any injury or other traumatic average. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2√ No þ Specify: 3 XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer Various Jobs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Alexander Almena Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred M. Marcus-Son 4637 Rokeby Road, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Garrison Forest Vet. 11/17/04 Owings Mills. 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

22. Signature of Funeral Service Licensee

23. Signature of Funeral Service Licensee

24. □ Donation 5 □ Other (Specify) March F/H West 4300 Wabash Ave, Baltimore, 21215 Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ADENOGARCINOMA 2 MENTER resulting in death /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery in the past 12 mor 3 Ectopic pregnancy 4☐Pregnant at time of death Month 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 1 Tyes 2 4€N6 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No Other: Certification: To 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier ath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 00 Ove, BAT,

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Box 68760.

P.O.

Division of Vital Records,

32. Registrar's Signature

			1- State of Maryland / Department of Maryland	artment of Health and rtificate of Death	Mental Hygie	2006 35093
i	Physici /Medic		1. Decedent's Name (First, Middle, Last) Archie R. Moler		2. Date of Death Month November	Day Year 7:10a M
4	Examir		4a. Facility Name (If not institution, give street and number) Lorien Nursing Center	4b. City, Town, or Location of Deat Mt. Airy		4c. County of Death Carroll
	Funeral Director		5. Social Security Number 220-16-2152 G. Sex TM 2 F 7. Age (In yrs. last birthday) Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug 3 192	
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1∭Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 331 Kalorama Road	10f. Zip Code 21784	10g. US	Citizen of What Country?
036	72 hours after death with the Maryland natural, or Items 23e or 28e-f show deat Exp. clief natified at	by Funeral	Amed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No τ,π,τ⊤⊤	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within ene. than	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) 21 Worker	rking	o. Kind of Business/Industry
yland 2	be filed ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Last) Archie C. Moler	Leviah	ne <i>(First, Middle, M</i> ai Pumphrey	
, Mar	nd 2 sh alth and 27 is m r traum		Rhonda Singley (daughter) 331 K	ng Address (Street and Number or Ro Kalorama Rd., Syko	esville,Md	21784
altimore,			*4 Donation 5 Other (Specify) Meadowrid	osition (Name of matory or other place) Ige Memorial 11-1		c. Location - City or Town, State
Ball	permit. Page Department o Important: If any injury or once.		Dauge Haught Sterbert P.			ral Home & Chapel 21784
	death certificate be executed Wedgical Battending physician and dor use as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	re Hean	Zi'(y	Interval Retween
O. Box 68	the che	Physiclan/Medical		Ectopic pregnancy		23d. Date of delivery Month Day Year
ds, P.	as the gned be de	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ᡚ Onknown
Vital Records,	The law ate has t page 2 s	Completed			24a. Was an autopsy performed	
of	Attending Physician: r death. ector: After this certific. by the funeral director.	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Pending 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	nt 3□ DOA Other: 4 Mursing H	ath (Check only one) lome 5 Residence 28d. Describe how in	e 6 □Other (Specify) njury occurred
Division	in the	Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death one in the control of	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	Tot Tot Tot	M	29b. Signature and title of certifier	29c. License number Dy3725		Date signed (Month, Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, TA2-(Q MAHMOUD 201-109)	Back River	Neck K	Ed Balfinde
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 5 2004	ري		

Jerome Massey 04-7217 UNK AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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State of Maryland / Department of Health and Mental Hygieneo O.L.	25021
State of Maryland / Department of Health and Mental Hygiene O L	33924

0	4-363		1 - For State Registrar	State of Maryland /	Cer	artificate of	ieaiin an Death	d Mental H	Reg. No	007	35924
	Physici		Decedent's Name (First, Middle, La Jerome Kevir		_	<u> </u>		2. Date of Month	Death Day	y Ye	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, o	r Location of D	Nover eath		7 <u>200</u> County of D	
			University Hospit			Baltimo				N/A	
	Funeral Director		5. Social Security Number 219-06-0879 6. S	Fex 7. Age (In yrs. last bi	Yrs.	If Under 1 Year Months Days		Min. 8. Date of (Month,	Birth Day, Year) 5	1984	Birthplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Lo	cation					10d. Inside City Limits
	Maryl B-f sho	tor	Maryland N/	A I	Bal	timore					1½ Yes 2 □ No
	th with the 23a or 28 list be not	al Director	10e. Street and Number 506 Orchard St	reet		10f. Zip Code 2120	1			izen of What SA	Country?
980	be filed within 72 hours after death with the Maryland ital Hygiene. Indother than "netural", or Itams 23a or 28a-1 show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba		(Specify Yes or uerto Rican, etc.)	No-		merican Indian, /hite, etc. lack
215-0	within 72 hc ene. than "netu he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	Deced (Give life, L	lent's Usual Occup kind of work done OO NOT use retired	ation during most of d)	working		ind of Busine	Industry
21	e filed within at Hygiene. other then vent, the Me	Сош	11th grade		La	borer				<u>-</u>	Industry
land	should be fill of Mental H markad oth	То Ве	17. Father's Name (First, Middle, Last, Jerome Massey)				Name (First, Midd Ce John		Sumame)	
Maryland 21215-0036	nd 2 should alth and Men 27 Is marka ir traumatic		19a. Informant's Name/Relationship (Yvette Johnson		Mailin 06	g Address <i>(Street</i> Orchard	and Nymber or Stree	et Balt	iber, City o	e, Ma	ryfand2120
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marka any injury or othar traumatic once.		20a. Method of Disposition 1	20b. Place of cemete Removal from State New C	of Dispos ery, crem ath	sition (Name of natory or other place edral	emetei	/13*/04 cy	Bal	cation · City timor	or Town, State e, Maryland
Balti	permit. Pages. Department of H Importent: If ite any injury or of once.		21. Signature of Funeral Service Live	see		Name and Addres					Funeral H
Г			Shock, or near vallure. List only	44					arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	-	nshot v	vounds	<u> </u>	-		Short and Dodgi
1		liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence	of):					7.	
ox 68760, <	tificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c	of):						
68760,	cate be physicia the bu	Medical	(d						-	
.O. Box 6	death	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			2	23d. Date of o	delivery Day Year
s, P.	law requires that the de as been signed by the a 2 should be detached f	by Ph	Part II. Other significant conditions of	contributing to death but not resulting in	n the un	derlying cause give	en in Part I,	23e. Dio	tobacco u	se contribute	to the cause of death?
ord	w require been sig should t						·	_ 1 [Yes 2	X No 3□	Probably 4 Unknown
al Record	The ate h page	Completed							opsy formed?		autopsy findings available o completion of cause of ? es 2 \square No
Vital	Physiclan: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ∑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 SER/Ou	tootion!	3 DOA Othe	ar	Death (Check only			
l of	ding Phys h. After this funeral di		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 28b.	Time of	28c. Injury Work		g Home 5 ☐ Re: 28d. Describe	how injury	occurred	
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ρ		Certification:	4 Homicide determined	building, etc. (Specify)	معار المال			City or To	own, State)		Rural Route Number, plock of Houf
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•			30 Name and address of access it to	m i D	/Tues 5	O.C.	М.Е.		Nove	ember	8, 2004
			30. Name and address of person who	ocpiotod cadae of death (Rem 23a)	() Ahe' I	THIL)					

State Registrar

LING LI, M.D

31. Date filed (Month, Day, Year) 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

NUV 1 5 2004

State of Maryland / Department of Health and Mental Hygiene 004 35925 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month James Earl Merryman Nembe 200 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner City, Town, or Location of Deeth 4c. County of Death Mary land 5. Social Segurity Number tospital nera If Under N/A 8. Date of Birth (Month, Day, Year)

June 15,1954Maryland 7. Age (In yrs. last birthday Birthplace (Stete or Foreign Country) **Funeral** Hours Min 216-68-5124 1₩ M 2□F Days Director 50 June Usual Residence of Decedent Manyland 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28s-f show 10d. Inside City Limits the Medical Examiner must be notified at Maryland N/A Baltimore Director XXYes 2 □ No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2810 W. Coldspring Lane 21215 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Dopartment of Health and Mental Hygine 1 poperation of Health and Mental Hygine 1 if itsm 27 is marked other than "natural", or it may injury or other traumatic event, the Medical Examination. 1 ☐ Yes 2 ☑ No Specify. þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 9th grade Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Joseph Merryman Ila Pearl Demonia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2810 W. Coldspring Lane Baltimore, Md 21215 Ila Pearl Kennedy/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11/20/04 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park * 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, Maryland 21. Signature of Funeral Service Libersee 22. Name and Address of Facility Chatman-Harris Funeral Home ere 5240 Reisterstown Rd Baltimore, 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysician Immune /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to limit ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Hospital or Attanding Physician: The law requires that the death certificate be executed and physician ar s the burial-t Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE 957 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Day Year 5 Other (specify) ed by the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funsral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 - Homicide filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) porodatchere_ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria borodatcheva n.D 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Gener NOV 1 5 2004

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, I'm Medical Exam are must be notified at once.		FAYE MCDONAI 20a. Method of Disposition	LD BOY	EK			ONSTON I	DRIVE.	LAUF			0707 cation - City	or Tow	m. State
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			1- For State of Maryland /		artment of H		Mental Hy	giene 0 (14 35927
	Physic		1. Decedent's Name (First, Middle, Last) Charles Joseph McGinle	—— еу,	Jr.		2. Date of De Month	eath Day	3. Time of Death
7	/Medi Exami		4a. Facility Name (If not institution, give street and number) 1637 Inverness Avenue		4b. City, Town, or Balt			oer 6, 20 4c. County (
	Funeral Director	Г	5. Social Security Number 6. Sex 1 ₹ M 2 □ F 62	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	30,1942	9. Birthplace (State or Foreign Country) Pennsylvania
	death with the Maryland ms 23a or 28a-f show LTLIST DE notified at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	wn or Lo	cation				10d. Inside City Limits
	the Ma 28a-f s	cto	Maryland N/A		Ва	1timore			1 Yes 2 □ No
	ath with the Maryle 23a or 28a-f show ust be notified at	Die	10e. Street and Number		10f. Zip Code			10g. Citizen of W	•
	eath w	eral	1637 Inverness Ave. 11. Marital Status 12. Was Decedent Ever in U.S.	12.1		230-1111		United	
980	after or ita	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 2 Was Deceded to 12. Was Deceded to 15. Agmed Forces? 1 Yes 2 No If Yes, Give Year or Dates: (Unknown		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2🏋 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	Specify:	- American Indian, k, White, etc. White
2-0	72 hours "natural",	eted		a. Deced	dent's Usual Occupa	tion		16b. Kind of Bus	siness/Industry
21215-0036	od within rgiene. ar than "i	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done di DO NOT use retired) aboratory			Medi	cal
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natur any injury or other traumatic evant, Ita Mudical ange.	To Be (17. Father's Name (First, Middle, Last) Charles J. McGinley,	Sr.		18. Mother's Nam Mary	e (First, Middle	Maiden Sumame Wa1	
	and 2 sho halth and 1 127 is mu				g Address (Street at Village		a/Route Numb oylesto		State, Zip Code) 18901
Baltimore,	Pages 1 and of He		1 ☐ Burial 2X Cremation 3 ☐ Removal from State	ary, crem	sition (Name of natory or other place e Cemator	Nov.	12 04		City or Town, State
Balti	permit. Departm Importa any inju		21. Signature of Funda Sance Lidospe Moo382	22 R	Name and Address app Funer 33 Gist A	of Facility al and C	rematio	n Servic	
			23a. Part1. Enfer the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	or the mode of dying	, such as cardiac	or respiratory a	rest,	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Atherosclentic (Due to (or as a consequence)		diovascul	ar dis	ease		Interval Between Onset and Death
12	Examiner	er	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying	ot):					
	ecuted and -transit	Examiner	that initiated events c.						
68760,	icate be executed physician and s the burial-transit	dical E	Due to (or as a consequence of d.	of):					
О. Вох	faw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Oth <i>er (specify)</i>			23d. Date Monti	,
ecords, P.	v requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in	n the und	derlying cause given	in Part I.			oute to the cause of death?
α	9 2 9	Completed					24a. Was autop perfor	sy prid med? de	ere autopsy findings available or to completion of cause of arth?
Vital	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			26. Place of Death			(163 20140
of \	Phys this al dii	5	1X Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out			4 Harsing Ho			Charles and the contract of th
on	ding After fune	tlon	1 Natural 5 Pending (Month, Day Year) Ir	Time of njury	28c. Injury a Work? M 1 □ Ye		28d. Describe h	ow injury occurred	
Division	Attanding er death. ractor: After by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far	rm, stre		s 2 No	28f. Location (S	treet and Number	or Rural Route Number,
۵	pital or ours after aral Dire		Building, etc. (Specify)				City or Tow		
	To the Hospital or Attani within 24 hours after deatl To the Funaral Diractor: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge. 2 Medical Examiner: On the basis of examination and manner stated.	death dor inve	estigation, in my opir	nion, death occurr	ed at the time, o	late and place, and	d due to the cause(s)
	To Cor		29b. Signature and title of certifier		29c. License r	number		19d. Date signed (1 November	Month, Day, Year) 7 2004
	5+1		30. Name and address of person who completed cause of death (Item 23a) (reet. Ba			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	Registr	ar	NOV 1 5 2004 General &	00	and				

			For State Registrar	State of Maryland	Department of Certificate		lental Hygier	ZUUL	35928
	Physici	an	Decedent's Name (First, Middle, Last)		01.		2. Date of Death Month	Day Year	3. Time of Death
	/Medi	al	HUGUST 4a. Facility Name (If not institution, give stre	pet and number)	TAOLINO AD CON TO	wn, or Location of Death	11- /	3- 04/	9,52 9 M
	Examir	er •	r : 0 11	ortal Center	Prose C	1 1	1	Baltimore	> ,
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Y		8. Date of Birth (Month, Day, Yea	9. Birthp	lace (State or Foreign
	Director		2/6-16-6569 12/N Usual Residence of Decedent	80	Yrs. Months		FeB 13, 1	924 MA	RYLAND
	ryland how		10a. State 10b. County		own or Location			1	0d. Inside City Limits
	with the Maryland a or 28a-f show be natified at	Director	MARYLAND BAITIMO	re	Essen				1 □Yes 2 No
	with to		10e. Street and Number 2315 RIVERSIA	le Drive	10f. Zip Co	21221	10g. (Citizen of What Cour	itry?
	death	Funerai		Was Decedent Ever in U.S. Armed Forces?		t of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
36	s after , or ite	by Fu	1 Never Married 2 Married	1 Yes 2 No WW	1 ☐ Yes 2X	,	Hican, etc.)	Black, White,	etc.
215-0036	within 72 hours after death with the Maryland ane. then "natural", or Items 23a or 28a-f show is Madical Examinet must be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educat	Year or Dates ARMy	Sa. Decedent's Usual O	ecupation	16b	Kind of Business/Inc	nite
215	thin 72 e. an "na Madii	Completed	(Specify only highest grade c	ompleted) College (1-4or 5+)	(Give kind of work of life. DO NOT use n	lone during most of working tired)	ng		,
25	led willygien her th		7+1		Kestaur				AB House
Maryland	ges 1 and 2 should be filed within 72 h t of Health and Mental lytgiene. If item 27 is marked other than "natu or other traumatic event, It a Michal	o Be	17. Father's Name (First, Middle, Last) ENRICO	P	20/100	18. Mother's Name	e (First, Middle, Maid	Co M	
ary	should ind Men s marke umatic	P	19a. Informant's Name/Relationship (Type,	Print) 1	9b. Mailing Address (Si	reet and Number or Rura	al Ro te Number, City	or Town, State, Zip	Code)
1	and 2 saith a n 27 is		ANNABELLE PAOLIN	0-WIFE &	315 Rive	rsipe Dr.	ive Ess	ex, MD	2/22/
altimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. 20008.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Place ceme	of Disposition (Name of tery, crematory or other	of [r place)	Date 20c.	Location - City or To	wn, State
E	it. Pa intmen intent: njury		*4 □ Donation 5 ☑ Other (Specify) ☐ 21. Signature 5 Juneral Spring Licensee	Homement Most	Holy Kede	ener!11-18	-2004 B	Altimore,	MARY /ANT
Ba	permit. Departn Imports any inju) ()		Joseph	ddress of Facility N ZAA CONKLING	ST BA	2140 M)	121224
	4 .		23a. Part1. Enter the ase, or complicate shock, or heart silure. List only one	tions that caused the death. D					Approximate Interval Between
	Physician		Immediate Cause Final disease or condition	Acute Myocar	dial Inface	tion			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a sequence					
L		er	Sequentially list conditions, if any, leading to inmediate	Drie V (Gras a consequence	ie (f):				1,000
V	cuted nd ransit	Examiner	dary, leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Right Sided F	ney mone				
8760,	ate be executed any sician and the burial-transit		resulting in death) Last	Due to (or as a consequence	e of):				
687	ate thys	dicai	d	Urinary Tra	IET LA FECTIO	207			
Box (eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnancy 1□Live birth 2□Fetal dea	а ПЕ			23d. Date of delive	ry
. B	ne death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death				Month	Day Year
Division of Vital Records, P.O.	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Dther significent conditions contril	outing to death but not resulting	I in the underlying cause	e given in Part I	23a Did tobacco	use contribute to th	a cause of death?
ds,	uires tha signed Id be de	Completed by	Cardio muo pathy .]	Diabetes Melli	tus	o given in ruici.		2⊠No 3□ Prob	
CO	aw require s been si s should t	ojete	End Stage Beng 1	150050			24a. Was an	24b. Were autor	osy findings available
l Re	The lav ate has page 2:	mo	210 01100	,			autopsy performed? 1 ☐ Yes 2 Ø N	death?	npletion of cause of
/ita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	mitels		26. Place of Death			
of	Physi r this c ral dir	- To	1 105 2 2 100		Outpatient 3 DOA Time of 28c.		ne 5 Residence 28d. Describe how inj)
ion	nding F ath. r: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b		Injury at Work? 1 ☐ Yes 2 ☐ No	1041 2000120 11011 111	ary cocarrod	
N N	or Attendi after death. Director: A in by the fu	Certification:	a Could not be	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, of	fice	28f. Location (Street a City or Town, Sta		Route Number,
0	pital o urs aft aral Di	Cer							1
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physici (Check only one) 1 Medical Exeminer	 en: To the best of my knowled On the basis of examination and manner stated. 	ge, death occurred at the and/or investigation, in a	ne time, date and place, a my opinion, death occurre	and due to the cause(ed at the time, date a	s) and manner as stand due to	ated. the cause(s)
	To th within To th	Me	29b. Signature and title of eertifier	0	29c. Lie	cense number	29d. D	ate signed (Month, L	Day, Year)
			1 Orgen	> m	D D5	6381	11-	13-04	
	1041		30. Name and address of person who comp	oleted ause of death (Item 23a	(Type, Print)	S. D.	10 R 11.	co HII o	11000
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	L	Square Dri	ve Dallim	vie, 170 2	1201
	Registi	ar	NOV 1 5 200	14 Cenera	p pp	metal			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 22 per fib 2837 11-15-04. Yth and Mental Hygiene 00 light State of Maryland Department of Health and Mental Hygiene 00 light 35929 Certificate of Death Reg. No. 2. Date of Death Month NOV • 1 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day ELMER CARROLL PRESTON 10, 2004 1335

Physician /Medical Ex

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours atter death. To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

r ľ	4a. Facility Name (if not institution, give site				MORE CI		N/	A				
	Social Security Number	7. Age (In	yrs. last birthday		r If Under 24		y Year) 9	. Birthpleca (State or Foreign Country)				
	2.0 30 000	^{M 2□F} 64	Yrs.	World 3	110013		0, 1940	Maryland				
-	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits				
I	Maryland N/A		Bal	timore				1 ∑Yes 2 □ No				
-	10e. Street and Number			10f. Zip Cod	at Country?							
ļ	1826 N. Broadway		in 11.0		213	2 (Casata Vas as No.	USA o- 14. Race - American Indian,					
	11. Marital Status 1 Never Married 2 Married	?. Was Decedent Ever Armed Forces? 1 ☐ Yes 2€5No	10.5.	If Yes, specify C	iban, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)		White, etc.				
	3℃ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠X1	o Specify:		Specify:	Black				
	15. Decedent's Educa (Specify only highest grade of		16a. Dec	edent's Usual Oc re kind of work do DO NOT use re	upation ne during most o	f working	16b. Kind of Busin					
	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)		chanic	rea)	1	Kunkel' Service					
-	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Sumame)					
	Leroy Preston				Doi	othy Dan	iels					
-	19a. Informant's Name/Relationship (Type		19b. Mai	ling Address (Str	et and Number	or Rural Route Numbe Baltimor	r, City or Town, St Marv	ate, Zip Code) Land 21213				
-	Dorothy Moals/ Mo						20c. Location - Ci					
	1 XBurial 2 ☐ Cremation 3 ☐ Rer	moval from State	cemetery, cri	oosition (Name of ematory or other on A.M.	olace) 11 E. Ch.	/15/04		en, Maryla				
1	' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licentee			22. Name and Ad	tress of Facility(Chatman-H	arris F	uneral Home				
	Dewy Her	ni	5	240 Re	sterstow	cowsn Roa	d Balti	more,Md212				
1	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do not e	nter the mode of	lying, such as ca	ardiac or respiratory ari	rest,	Approximate Interval Between				
	shook, or heart faflure. List only one cause on each line. Immediate Cause (Final Discourse Conset and Death Conset and Deat											
	disease or condition resulting in death) a. A											
Sequentially list conditions.												
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 23 2 00	insoquentes on.									
	that initiated events c. resulting in death) Last	Due to (or as a co	nsequence of):									
	L d.											
	IF FEMALE:		W 6									
	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of p 1 Live birth 2 4 4 Pregnant at time 	Fetal death 3	Ectopic pregna			23d. Date of Month					
	1 Yes 2 No	9 Unknown	e or death = 5	Other (specify								
	Part II. Other significant conditions conti		ot resulting in the	underlying cause	given in Part I.			ute to the cause of death?				
2	Colon Caucer	•				1 🗆 Y	'es 2□No 3	☐ Probably 4 Unknow				
						24a. Was a autop		ere autopsy findings available or to completion of cause of				
						perfor	med? dea	ath?]Yes 2□No				
- 1	25. Was case referred to medical examiner?	ital:			0.1	of Death (Check only or		лп сст				
	examiner? XXYes 2 No	ospital: 1 Inpatient	2 ER/Outpati	ent 3LI DOA	Other: 4 Nurs	sing Home 5 ☐ Resid	lence 6 X Other	(Specify)				
	examiner? XXYes 2 \(\text{No} \) 27. Manner of Death 1 \(\text{Natural} \) 5 \(\text{Pending} \)	ospital: 1	28b. Time	of 28c. I	0.1	sing Home 5 Resid		(Specify)				
	examiner? XXYes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day Ye	28b. Time Injury	of 28c. I	Other: 4 Nurs	28d. Describe h	ience 6 Cother	(Specify)				
	examiner? XXYes 2 No 27. Magner of Death Xatural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	28b. Time Injury	of 28c. I	Other: 4 Nurs	ing Home 5 Resid	ience 6 Cother	(Spacity)				
	examiner? XXYes 2 No 27. Magner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physic	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (S	28b. Time Injury At home, farm, specify)	of 28c. I	Other: 4 Nurs	28d. Describe h 28f. Location (S City or Tow	Hence 6 Cother now injury occurred Street and Number m. State)	or Rural Route Number,				
Oct micanonii 10 pc	examiner? XXYes 2 No 27. Magner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) Condition of the determined Ho Homicide Homicide Fraction of the determined Homicide Fraction of the determined	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (S	At home, farm, specify) y knowledge, deamination and/or	of 28c. I M street, factory, off	Other: 4 Nurs	28d. Describe h 28f. Location (S City or Tow place, and due to the coccurred at the time, co	lence 6 Other now injury occurred and Number m. State)	or Rural Route Number, ner as stated. d due to the cause(s)				
Medical Certification; To be compile	examiner? XXYes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Examine	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (S ician: To the best of m er: On the basis of exe	At home, farm, specify) y knowledge, deamination and/or	of 28c. I M 28c. I ath occurred at the investigation, in n 29c. Lic.	Other: 4 Nurs	28d. Describe h 28f. Location (S City or Tow place, and due to the coccurred at the time, co	lence 6 Other now injury occurred street and Number m. State) cause(s) and mannifate and place, and place, and place, and place, and place and place).	or Rural Route Number, ner as stated. d due to the cause(s)				

State Registrar 31. Date filed (Month, Day, Year)
NOV 1 5 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiepen 0 [35930 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year November 10, 2004 **Physician** Pau1 0. Pryor 2:15 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 13,1944 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Min 15 M 2□ F Illinois 345-36-9758 60 **Director** Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours atter deeth with the Maryland nent of Health and Mental Hyglene.
nnt: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any or other traumatic event, the Medical Eventual be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Gaithersburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Quince Mill Court 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 Respiratory Therapist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudolphuy Pryor Millard Georgia Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie A. Pryor / Wife 1 Quince Mill Ct., Gaithersburg, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Nov. Date 19. cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit, Pege Department of Importent: if any injury or once. Chesapeke Crematory 2004 Beltsville, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Rapp Funeral and Cremation Services Statest noun M00382 933 Gist Ave., Silver Spring, MD Approximate Interval Between On, et and Death 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lungermo **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Lîve birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certiticate has b irector, page 2 s autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Atter 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 29c. License number M) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 7 MENDH1 240 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygier 0 0 1 35931 1 - For State Registrer Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Roland L. Payton, Jr. 8:40 PM /Medical November 10,2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris at Mercy Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2□F Months Hours 59 Yrs. Director 219-40-0591 Dec 4, 1944 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other then "neturel; or Items 23e or 28e-f sho other traumatic event, I'm Madical Examinar must be notified at Funeral Director MD 1 Yes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 916 Belgian Avenue, 21218 Apt. B1 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:
Black Be Completed by 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) be filed within 72 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "ne eny injury or other traumatic event, the Wade. Transportation Elementary/Secondary (0-12) College (1-4or 5+) 8 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roland L. Payton, Sr. Bernice Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. India Payton/Daughter 4216 Ivanhoe Avenue, Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Nov 15 * 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Beltsville, MD 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives JEPOOM Hull 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 monodeficier Hoyswed /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) o 9 🗆 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? res 22 No certificate 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NoSpice 1 ☐ Yes 2 ☐ No Certification; To this Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation M 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1111212004 10851 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST Paul Riseberg Ochumore md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 5 2004 Registrar

PAYTON, Roland

			For State Registrar	State	of Maryla		artment of F			giene Reg. No.	004	35932
	Dhusisi		Decedent's Name (First, Middle, Last)			NT			2. Date of Death Month November		Year	3. Time of Death
	Physicia /Medic			Paul:		N.	Penning					3:57 A M
	Examin	er	4a. Facility Name (If not institution Johns Hopkins	=		Ctr		r Location of Death Ore City	1	4c. (County of Deatl	n N/A
			5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year		8. Date of Bir	th	9. Birth	hplace (State or Foreign
	Funeral Director		235-40-1185	1 □ M 204F	92	Yrs.	Months Days	Hours Min.	(Month, Da Aug. 1	ıy, Year)	Co.	untry) st Virginia
	been signed by the attending physician and should be detached for use as the burial-transit of being be detached for use as the burial-transit of being been signed by the attending physician and should be detached for use as the burial-transit of being		Usual Residence of Decedent		-				, 1149			
		_	10a. State 10b. County		10c. C	City, Town or Lo		ltimore (7.4			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
21215-0036		octo	Maryland N/A				CICY	10- Citie	zen of What Co			
			6107 Cardiff Avenue			10f. Zip Code 21224					ted Sta	
		erai	11. Marital Status		cedent Ever in	U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		4. Race - Ame	
		by Funeral Director	1 ☐ Never Married 2 ☐ Marriad 3 ☒ Widowed 4 ☐ Divorced	ied Armed F 1 ☐ Yes If Yes, G	orces? 2 ⊊No iive		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		o Rican, etc.)		Black, White Specify: Wh	
		To Be Completed		t's Education	n	16a. Dece	dent's Usual Occup	pation	dian	16b. Kin	nd of Business/	Industry
215			(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			life.	Killy					
Maryland 21			12 Years			Ho	memaker		/***		n Home	
			17. Father's Name (First, Middle, Arden Lewis	Last)				18. Mother's Nan Bertha		, Malden S	Sumame)	
Z			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
			Mr. Lewis E. Pe	ennington	/son	52	Rockywoo	d Lane Es	ssex, Ma	aryla	nd 212	21
ře,			20a. Method of Disposition			Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. Loc	cation - City or	Town, State
Ē			1 Burial 2 Cremation Donation 5 Other (S		bment	Lakevie	ew Cemete	ry 11/11	/2004	Sy	kesvill	e, Maryland
Baltimore,			21. Signature of Funeral Service	Licenses	an l		2. Name and Addre Duda-Ruc 7922 Wise	k Funera	l Home o	of Du Mary	ndalk, /land	Inc. 21222
			23a. Part1 Piter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between									
			Immediate Cause (Final disease or condition	Ati	rial f	152.1La	tion will	4 rapid	1 vent	vicil	a regno	Onset and Death
			Immediate Cause (Final disease or condition resulting in death) a. Atrial fibilitation with rapid ventricita regime. Due to (or as a consequence of): Atherwise suite countary veneral disease. b. Atherwise suite countary veneral disease.									
V.5		ē	Sequentially list conditions,	b. Due to	(or as a conse	equence of):	9 Je	a) t		· · · · · · · · · · · · · · · · · · ·		
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	5 . Ha	pertu	idemia						
o,		Еха	resulting in death) Last Due to (or as a consequence of): d.									
8760,		d by Physician/Medical										
39 ×			IF FEMALE:	23c. If yes, o	utcome of preg	nancy	ncy			2	23d. Date of delivery	
Вох			23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Fe gnant at time of							
P.O.			9 Unknown 9 Unknown									
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 3 Probably 4 Unknown									
OS		plete	Peripheral (iseas		24a. Was an autopsy prior to comp		topsy findings available completion of cause of				
<u> </u>	, c	Be Completed	Cerebrovascular occident performed? death? 1 yes 2 No 1 yes 2 No									
Vita	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag		25. Was case relerred to medica examiner?	Hoonital		_	Oth	26. Place of Dea				
of		7	1 Yes 2 No 27. Manner of Death	28a. Date	1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?							
o		Certification:	1 Natural 5 Pendir 2 Accident investi	nth, Day Year)	ar) Injury Work? M 1 □ Yes 2 □ No							
Division of Vital Records,			3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	pined 289. Plac						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
_		Medical C	29a. Certifier (Check only one) Certifier (Check only one) Check only one) Check only one) Continuous Certifier (Check only one) Certifier (Check only one) Continuous C									
	ro the within To the	Me	29b. Signature and title of certific			29c. License number				29d. Date signed (Month, Day, Year)		
			ASY				04	1399		I_I	13/04	
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore Stephens, M.D. 1005 North Pt. Blvd. Suite 724 Baltimore, MD 21224									
	Sta Registr		31. Date filed (Month Cay Yar)	5 2004 32.	Registrar's Sig		Spar	ta)				

*		Registrar 1. Decedent's Name (First, Middle, Last)						2. Date of De Month		ay Yea	3. Time of Death	•
Physicia /Medic		Oscar	J.		Russ	ell		Nov.	1,2	004 Yea	9.55A M	
xamin		4a. Facility Name (If not institution, give s	treet and number)				ocation of Deat	h	40	County of De	ath	_
		Forest Glen Nur					Spring	T = 0		Monto		_
eral ctor		218-07-9127	M 2□F	(In yrs. last bir	Yrs. Month		Hours Min.	Jun.1	orth ay, Year 0,1	917 Ma	irthplace (State or Foreign Country) aryland	
ם		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				-		10d. Inside City Limits	-
event, the Medical Examiner must be notified at	ctor	D.C.		Washi	ngton						1∏Yes 2□No	
De no	Funeral Director	10e. Street and Number 1378 E. Capital	S+ NF			Zip Code			10g. C	itizen of What (USA	Country?	
	era		2. Was Decedent E				panic Origin? (S	pecify Yes or No o Rican, etc.)	D-	14. Race - An	nerican Indian,	-
	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	0		pecify Cuban	, Mexican, Puerl Specify:	o Rican, etc.)		Black, When Specify: B		
	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a.	Decedent's Us	sual Occupat	tion	rkina	16b. I	Kind of Busines		-
	mple	Elementary/Secondary (0-12)	College (1-4or 54				iring most of wo	Arry .	Ci	tu of	Baltimore	
vent, Ib	ပိ	12th 17. Father's Name (First, Middle, Last)		اظ	nginee		18. Mother's Nar	ne (First, Middle			Daitimore	_
raumatic eve	To Be	Unknown					Unknow					
		19a. Informant's Name/Relationship (Type		1				Iral Route Numb				
		Patryce Campbel 20a. Method of Disposition	ll (Daug	20b. Place of	Disposition (A	lame of	1	Date		ocation - City of		_
		1 Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ry, crematory`o r Hill			8/2004	Bro	oklyn,	, Maryland	
once.		21. Signature of Funeral Service License		1				i-Stat				
a =		any Thu	real							gton,	D.C.20001	_
ician dical		23a Part 1. Enter the disease, or complications and complications of the complex completes the complex completes the complex completes the complete completes the complete completes the complete completes the complete completes the complete completes the complete completes the complete completes the complete completes the complete the completes the complete the completes the completes the completes the completes the completes the completes the completes the completes the completes the completes the completes the completes the completes the com	e cause on each line Arrytan Due to (or as a	_{e.} nia ^A	rryth		, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death 1 Day	
2	Il Examiner	Sacuratedy list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a	consequence	of):	ion					1 Day	
sine	edlcal	d										
delacried for use as me o	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	2 Fetal death	3 ⊟Ectopic 5 ⊟ Other (23d. Date of d Month	lelivery Day Year	
	by Pi	Part II. Dther significant conditions con Hypertension	tributing to death bu	t not resulting i	n the underlying	g cause giver	n in Part I.		obacco Yes 2		to the cause of death? Probably 4 Unknown	
Dinous	etec	Cerebrovascula	r Accide	nt				24a. Was			autopsy findings available	_
page 2	Comp		1 Accide					auto	psy omed?	prior to death?	completion of cause of	
director.	Be	25. Was case referred to medical examiner?	ospital:			Othor		ith (Check only				-
arai di	1.10	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	v 28b.	tpatient 3 1	28c. Injury	4 X Nursing h	ome 5 Resi			pecify)	-
d in by the funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) I	njury M	Work?	es 2 No					
	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, fa . (Specify)	rm, street, fact	ory, office		28f. Location (City or To			Rural Route Number,	
completely tilled in by it	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of er: On the basis of and manner stat	examination an	dor investigation	ed at the time on, in my opi	o, date and place nion, death occu	, and due to the rred at the time,	cause(s date an) and manner a d place, and du	as stated. ue to the cause(s)	
COLLOS	Me	29b. Signature and title of certifier	7. 1.		2	29c. License					nth, Day, Year)	
		Mellice f.	cal,			D1960	7.		11.	1.04.		_
		30. Name and address of person who co	mpleted cause of de	ath (Item 23a)	(Type, Print)							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 L 35934 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 2004 Catherine Ann Roesser 4:45 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Bay, Year) | 943 5. Social Security Number 9. Birthplace (State or Foreign Gountry) New York 6. Sex 7. Age (In vrs. last birthday) 1 M 2 XF 215-40-0229 61 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√☐ No Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1908 Pot Spring Rd. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Adminisrtative Assistant Accounting Firm 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Catherine McTeague John Sweitzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1908 Pot Spring Rd. Timonium, Md. 21093 Mr. Henry J. Roesser/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗌 Burial 2 💆 Cremation 3 🗌 Removal from State * 4 ☐ Donation 5 ☐ Qther (Specify) Hilltop Service Co. 11-11-04 Towson, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service License Approximate
Interval Between
Onset and Death
Munths 23a. Parti. Enter the disea , or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. mmediate Cause (Final CANCER una disease or condition resulting in death) Due to (or as a consequence of Due to (or as a consequence of)

permit. Pages 1 and 2
Department of Health an, importent; if item 27 is many injury or other Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

land 21215-003

Maryl

Baltimore,

Director

Funeral

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Completed

Be

burial-tran attending physician and the page 2

The law requires that the death certificate be executed

Hospitel or

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expense. within 24 hours after death.

To the Funerel Director; A completely filled in by the fu

resulting in death) Last	Due to (or as a consequ	uence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of do 9□Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlying cause given in Part I.	14	use contribute to the cause of death? 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed?	
25. Was case referred to medical examiner?		26. Place of D	eath (Check only one)	
1 Yes 2 No	ospital: 1 Inpatient 2 I	ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence	6 NOther (Specify) HOSPICE
27. Manner of eath 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury at Work? M 1 Yes 2 No	28d. Describe how inj	ury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28f. Location (Street a City or Town, Sta	und Number or Rural Route Number, te)
29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one) (Check only one)	ician: To the best of my kno- ler: On the basis of examinal and manner stated.	wledge, death occurred at the time, date and pla tion and/or investigation, in my opinion, death oc	ice, and due to the cause(courred at the time, date an	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier Ahm	y Riley.	29c. License number D 2 5 20 5		ate signed (Month, Day, Year) Verwher 10, 2005
30. Name and address of person who co	mpleted cause of death (Item	123a) (Type, Print) 6701 M. Charles J	7. Bolto	. md 2120x
31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture		

State

Registrar

	1	State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygier	2004 35935
		Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
Physicia /Medic		William P. Richardson		Nov. 11	, 2004 5:05 P M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		9064 Bellwart Way 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Columbia If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Howard 9. Birthplace (State or Foreign
Funeral Director		213-48-9633 ¹ XM ² 57 Yrs.	Months Days Hours Min.	(Month, Day, Yea	country) Country) Maryland
		Usual Residence of Decedent			
arylar show	_	10a. State 10b. County 10c. City, Town or a MD Howard Columbia	ocation		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
he M.	Director	10e, Street and Number	10f. Zip Code	100 /	Citizen of What Country?
with a or	늅		21045		
death ma 2:	Funerai	9064 Bellwart Way 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - American Indian,
after or Ite		Armed Forces? 1 Never Married 2 Married I Yes. 2 No If Yes. Give 4	If Yes, specify Cuban, Mexican, Puèrto 1 ☐ Yes 2 ☑ No Specify:	racan, etc.)	Black, White, etc. Specify: white
13-0030 172 hours after death with the Marylan "naturat", or fleme 23a or 28e-1 show sticul Examiner must be rediffed at	d by	3 ☐ Widowed 4 X Divorced Year or Dates:	••	Lagh	WIIICC
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12 shot and and lam		, , , , , ,	ing Address (Street and Number or Aura		
C, R 1 and Health em 27 ther t		20a Method of Disposition 20b. Place of Disp	York St., Apt. 1,		PA I/331 Location - City or Town, State
ages ont of t: If it		1X Burial 2 Cremation 3 DRemoval from State cemetery, cre	matory or other place) dge Mem. Park 11/1		kridge, MD
partitiore, inter yield A IZ I 3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygeine. Interpreter, it flem 27 is marked other than "naturat, or Itema 23a or 28e-f show any injury or other traumatic event, the Medical Evaninar must be multipled at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility		-
Deparimpool		Mgk. Hulman	ry L. Kaufman Fune 250 Washington Blvd	eral Homed 1., Elkrid	Meadowridje MP, Inc. ge, MD 21075
Marie Co		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Physician		discuss of condition	Cril Lymphone		Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):			
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s that	by PI	Part II. Other significant conditions contributing to death but not resulting in the	, , ,	23e. Did tobacco	use contribute to the cause of death?
en sig	ted t		kin uluration	1 🗆 Yes	2 No 3 Probably 4 Unknown
necolus, he faw requires t a has been signe ige 2 should be	Completed	Multiple courses of chimo	therapy.	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
The cate h	Con			performed?	death? No 1 Yes 2 No
VICIAN: Tician	Be	25. Was case referred to medical examiner? Hospital:	Othon	(Check only one)	
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tal or rs afte	Cert	Building, etc. (appeary)		0.1, 0.7.000.1, 0.10	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only (Check only) Certifying Physician: To the best of my knowledge, dea Medicel Exeminer: On the basis of examination and/or in			
thin 2 the orthe	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
F ₹ F 8		Dan 12 mint V MD	0 30573		12-64
16		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		
12		Jon & MINEURD 11065 Mit	the Buturent for		
Sta		31. Date filed (Month, Day, Year) 22. Registrar's Signature	. Mr. a	7	15 M
Registr	ar	WOV 1 5 2004 Alexan A for	(K)		

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	/Medic Examin		4a. Facility Name (If not institution,	give street and nu		<u></u>	4b. City, To	wn, or Loc	cation of		34 Charles		y of Death	
	LAGITIII	iC1	THE JOHNE HOP	kur Hos	PITAL		BA	cun	LOR	5 5	174			
	Funeral Director			3. Sex 1 □ M 2 □	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 \ Months D		Under 2 lours	Min	B. Date of Birth (Month, Day 07/01	Year)	9. Birth	place (State or Foreign ntry) ark, Ala
			Usual Residence of Decedent											
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	with ti		10e. Street and Number				10f. Zip Co					10g. Citizen of U.S.		ntry?
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an	t to b	o Be	Hubert Ramsey								Un	known		
Maryland	S D E E	-	19a. Informant's Name/Relationshi				•				Route Numbe			
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ore	ges 1 and it of Healt if item 2 or other		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation	B □Removal from	, C6	ace of Dispo emetery, crea	sition (Name natory or othe	of r place)	1,	Da	-04	20c. Location	•	
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Baltimore,	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service	Jay	len	11.7	2. Name and A	Capi	Facility	Tay 1 St	lor's .NW W	Funer ashin	tal I gton	DC 20001
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	/Medical Examiner		resulting in death)		(or as a consequ									2 - 0
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n c	ding P. h. After t funera		27. Manner of Death 1 ✓ Vatural 5 ☐ Pending		of Injury hth, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes	2 🗆 🗸		d. Describe h	ow injury occu	rred	
Division	Attending or death. ector: After by the funer	icat	2 Accident investigated as Suicide 6 Could no	ot be	e of Injury - At ho	me, farm, str			2 L IN		f. Location (S	reet and Num	ber or Rura	al Route Number,
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	/		30. Hame and address of person w			23a) (Type,	Print)			_ ~		SYEMISI		21287
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				artment of Health and Me rtificate of Death		iene 2004	35937
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	Physicia /Medic	al	Jack D. Rinker	1	Novembe	r 9, 2004	2:45 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Rockville		4c. County of Deatl	
	Funeral		Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birth	nolace (State or Foreign
	Director		226-32-8129 1X M 2 F 76 Yrs.	Months Days Hours Min.	(Month, Day, Sept. 27	, 1928 Vi	rginia
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
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	ith the	Direc	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Co	untry?
	s 23a	rail	1717 Grandin Avenue	20851		United Sta	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If tiem 27 is marked other than "natural", or tlems 23a or 28a-f show or tiem 27 is marked other than "natural", or tlems 20a or 28a-f show or other traumatte event, the Medical Evantrer must be rediffed at	by Funeral Director	11. Marital Status 11 Marital Status 12 Was Decedent Ever in U.S. Armed Forces? 1	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2☑ No Specify:	cry Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: W	
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	l and sealth om 27 her tr		William B. King/Friend/Executor 1717 20a. Method of Disposition 20b. Place of Disp			e, Maryland	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ance.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgome	matory or other place)	er 11,	Bethesda, 1	
altir	permit. P Departme Importan any injur		OI Chia C	orium, Inc. 2004 2 Name and Address of Facility Obert A. Pumphrey I			
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9			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	dical	d				
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Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death Other: 4 Days in the			
ō	Phys r this ral dir	. To	27. Manner of Death 28a. Nate of Injury 28b. Time	A Nursing Hom		nce 6 Other (Spec winjury occurred	ufy)
ion	Attending or death. ector: After by the fune	ation	1 Natural 5 □ Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	I or Attending after death. Director: After I in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	Bf. Location (Str. City or Town,	reet and Number or Ru. , State)	ral Route Number,
	pital o		29a. Certifier Gertifying Physician: To the best of my knowledge, dea	h convered at the time, data and place, as	ad due to the co	use(a) and manner as	eteted
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or is and manner stated.	vestigation, in my opinion, death occurred	d at the time, da	ate and place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29	ed. Date signed (Month	, Day, Year)
•			mendellestly	MD 13826	2 i	NOV 9, 2	004
	114,		30. Name and address of person who completed cause of death (Item 23a) (Type ALA MENDHICHTA 240)	Research Run	Sute	330 Rock	will mp
			31. Date filed (Namb Pax, Year) 52004 S2. Registrar's Signature	•			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U D Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 8, 200^{Year} Lucy Lorena Rick 7:12 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nursing Home Good Samaritan Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2QF 213-05-0906 88 Director 5/27/1916 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or items 23s or 28e-f show treumatic event, the Maxical Examination ust be mailtied at MD 1 ☐ Yes 2 X No Baltimore Director White Hall with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5511 New Park Road 21161 U.S.a. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status illed within 72 hours after ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White þ If Yes, Give Year or Dates: 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Be William Radcliffe Emma Stirn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is Beverly Preston/Daughter 5511 New Park Road White Hall, Maryland 21161 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department o importent: If Balto./Wash. Crematory 11/10/04 * 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland injury 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service Licensee J. WAS 6415 Belair Road Baltimore, Maryland 21206 23a. Part . Ent a the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or he ad allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIMER'S Physician DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 21 No 1 ☐ Yes filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner To Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitel or Attending 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated To the To the 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28987 11-9-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL SPERLING, M.D. 5601 LOCH RAVEN BLUD BALTO. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 5 2004 Registrar

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

		For Stete Registrar		Maryland / De	epartment of I Certificate of	Death	Re	g. No.	35940
Physicial /Medica		Decedent's Name (First, Middle Annie	Del			hens		Day 2004	3. Time of Death 17:34 M
Examine		4a. Facility Name (If not institution, University Ho	spital		Bali	or Location of Death		4c. County of Dea	ath
Funeral Director		5. Social Security Number 218-26-6594 Usual Residence of Decedent	6. Sex 7. A	ige (In yrs. last birtho	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ol 31	9. Bi	rthplace (State or Foreign Country) SC
aryland show	_	10a. State 10b. County		10c. City, Town o					10d. Inside City Limits
ith the Marylar or 28e-f show	22	MD NA 10e. Street and Number		Balti			1.4		1 XYes 2 No
3e or	2	819 Kevin Roa	ď		10f. Zip Code	.229	10	og. Citizen of What C U • S • A	,
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumatic event. The Medical Examiner must be instiffed at	completed by runeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Wildowed 4 Divorced	12. Was Deceden Armed Forces	? No	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian, ite, etc.
2 hou	מַר	15. Decedent'	Education		ecedent's Usual Occup	pation	1	16b. Kind of Business	Black s/Industry
Maryland 21215-0036 Id 2 should be filed within 72 hours aft this and Mental Hyglene. It is marked other then "naturel", or treumatic event, the Medical Exami	aldillo	(Specify only highest Elementary/Secondary (0-12) 8th grade	College (1-4or	(C /iii	ecedent's Usual Occup ive kind of work done e. DO NOT use retire COOK	during most of work d)			ecurity Adm
nd in the file of the file of the vent.	מ	17. Father's Name (First, Middle, L				18. Mother's Name			July Han
should be marked of marked		Robin Brunson					Fordha		
Mar d 2 sh th and 7 is m treum		19a. Informant's Name/Relationsh			ailing Address (Street				
re, N 1 and Health tem 27	Ĭ,	Pamela Hender 20a. Method of Disposition	icks-baug		sposition (Name of crematory or other place			Oc. Location - City or	
Baltimore, M permit. Pages 1 and Department of Health Importent: if item 27 importent: one 27		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp. 21. Sinhature of Funeral Service L	ecify)	9		Vet. 1	1/17/04	Owings	Mills, Md
rnysician /Medical Examiner		23a. Part1. Enter the disease, or of sheck, or heart talure. List of Immediate Cause (Final disease or condition resulting in death)	a Hyperten		enter the mode <i>of</i> dyir	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
68760, titicate be executed by physician and as the burial-transit	7	Sequentially list conditions, frame saiding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dirie to (una	s a consequence of):					
death certification of for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	,		23d. Date of de Month	livery Day Year
ords, P.O requires that the een signed by the nould be detache		Part II. Other significant condition RMOH CECEN	, ,	but not resulting in th	e underlying cause giv	en in Part I.		acco use contribute to	o the cause of death?
The law ate has b page 2 sl)						24a. Was an autopsy performe	ed? death?	utopsy findings available completion of cause of
Of Vital Physicien: T	1	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:	ent 20EP/Outpa	tient 3 DOA Oth	26. Place of Death		ce 6 ⊡Other (Spe	-41
ding Phy. After this funeral d		27. Manner of Death	28a. Date of Inju	ury 28b. Time	of 28c. Injun		28d. Describe how		city)
r Attendent ler death irector:		XNatural 5 Pending 2 Accident 3 Suicide 6 Could nc determin	t be 28e. Place of in	jury - At home, farm, tc. (Specify)	M 1 🗆	Yes 2 □ No	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
To the Hospitel of within 24 hours at to the Funerel D completely filled in Medical Cert		29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the best aminer: On the basis of and manner st	of examination and/or	eath occurred at the time investigation, in my of	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
To th within To th compl		29b. Signature and title of certifier	Collet	w	29c. License	o.C.M.E.		d. Date signed (Monti November 0	** *
0		30. Name and address of person w	ONIUA-TO	11AK	Penn Stree	et, Baltin		7,00	
State Registrar		31. Date filed (Month, Day, Year)		rar's Signature	Spore	and the second			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 11:03 ам Patricia Victoria Souchak November 11, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Phoenix 14601 Manor Road Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Director 215-32-5924 79 Yrs. July 24. 1925 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits it of Health and Mental Hygiene.
If item 27 is marked other then "natural", or items 23e or 28e-f show or other traumatic event, the Medical Examination at the modified at Completed by Funeral Director 1 Yes 2 No Phoenix Mď. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21131 USA 14601 Manor Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) g permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked 1 any injury or other traumatic eventors. John Dewey Catherine Gallagher Kuhns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Souchak/ Son 14601 Manor Rd Phoenix, Md. 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 11-13-04 Parkwood Cemetery Baltimore, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home 21. Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Massive ower 2 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examiner the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2XNo 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18807

State Registrar 31. Date filed (Month, Pay, Year) 2004

32. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

29005. Hanover St.

Baltimore MD 21225

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of Ma	ryland / D	epartment of H Certificate of L	ealth and M Death	ental Hygier Reg. f		35942
	Dhysisi		Decedent's Name (First, Middle, La	ist)				2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Charles (1		November	10 200	
	Examin	er	4a. Facility Name (If not institution, give STAGNES HE	ALTHCAR	۶		Location of Death		c. County of Dea	atn
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birt			8. Date of Birth (Month, Day, Yea		rthplace (State or Foreign country)
	Director		213-03-8194 Usual Residence of Decedent	1 ∑ M 2□F	87	rs.		May 18, 19	917 M	aryland
	yland now		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Mar	Director	Md. Balt	imore		Baltimore				1 ☐ Yes 2 🔀 No
	with th	Dire	10e. Street and Number		"410	10f. Zip Code		10g. (Citizen of What C	ountry?
	ns 23	Funeral	715 Maiden Choice	12. Was Decedent E		212 13. Was Decedent of Hi If Yes, specify Cubar		cify Yes or No-	USA 14. Race - Am	erican Indian,
920	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show odical Examiner must be rutillied at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:	0	If Yes, specify Cubai	n', Mexican', Puèrto F Specify:	Rican, etc.)	Black, Whi	White
21215-0036	72 ho "natur dical	Completed	15. Decedent's E (Specify only highest gra		16a.	Decedent's Usual Occupa (Give kind of work done of	lurina most of working	16b.	Kind of Business	
121		Jdmo	Elementary/Secondary (0-12)	College (1-4or 5-	-)	life. DO NOT use retired, Electric		Po 1	timono (Gas & Electri
10	i filed withi I Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last	")		Electric		(First, Middle, Maid		ads & Electri
/lar	should ba filed within and Mental Hygiene. Amarked other than umatic evant, Ire M	To B	David Franklin	n Seaman			Bessie	G. Unkno	wn	
Maryland	O 60 60		19a. Informant's Name/Relationship (Mailing Address (Street a			NIBOTO CONTRA	THE TAX CASES VISIO
	is 1 and 2 of Health item 27 other tra		Mr. Carl Seaman/So 20a. Method of Disposition	on	20b. Place of	3 St. Brides Disposition (Name of	Da	verna Park	Location - City or	
mo			1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special		1	y, crematory or other place y Valley Men	1	/15/04 Ti	monium	Maryland
Baltimore,	ir.		21. Signature of Funeral Service Lice	nsee	/ baranc	22. Name and Addres				Home, Inc.
8	Dem Impe		mohad	1 Russf		1050 York		son, Mary	land 212	
			23a. Part1. Enter the disease, or shock, or heart failure. List only Immediate Cause (Final	0		1	g, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)	- u	onsequence of					Unknown
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	rtificat ng phy s as th	Medical	IF FEMALE:		11103					
Вох	aath certif attending for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death	3 □Ectopic pregnancy			23d. Date of de Month	oliv ery Day Year
Ö	res that the de ignad by the a be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	ime or death	5 ☐ Other (specify)				
٩	s that inad b	by Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause give	n in Part I.	23e. Did tobacco	use contribute t	o the cause of death?
ords	w raquire been sig should b							1 ☐ Yes	2 □ No 3 □ P	robably 4 Dunknown
of Vital Records,	The la ate has page 2	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2 No
Vita	Phyaician: Th r this certificate ral director, paç	Be	25. Was case referred to medical examiner?	Hospital:		octiont 3C DOA Othe	26. Place of Death			
	Phys rthis ral di	To it	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day		me of 28c. Injury	at 2	ne 5 Residence 8d. Describe how in		ecify)
ion	돌도호호	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) In	jury Work	:? /es 2 □ No			
Division	Dir.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, far (Specify)	m, street, factory, office	2	8f. Location (Street : City or Town, Sta		ural Route Number,
	To the Hospital or Attan within 24 hours after deat To the Funeral Diractor: completely filled in by the	edical C	29a. Certifier Certifying Pl (Check only one) 2 Medical Example	hysician: To the best of miner: On the basis of and manner stat	examination and	death occurred at the tim for investigation, in my op	e, date and place, a pinion, death occurre	nd due to the cause d at the time, date a	s) and manner and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License			ate signed (Mon	2.3
7	D) - AAA) I	ND			6695		rember	10th 5001
	10		30. Name and address of person who STAGNES H			Type, Print) BABABALTIMO			MIPE	i mo
	. Sta Registr		31. Date filed (Month, Day 1917) 5	2004 32. Registra		& sport	ls)			

			1 - State Registrar	•	artment of Health and M rtificate of Death	lental Hygiei	211111	35943
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia /Medic		Barry James	Starr		November	r 8, 2004	9:00 P M
معر	Examin	er	4a. Facility Name (If not institution, give street and Spring Hill Court	d number)	4b. City, Town, or Location of Death Chevy Chase		4c. County of Death	.m.o.1417
-	F		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth	Montgo 9. Birtho	place (State or Foreign
	Funeral Director		166-32-0240 ¹ X ^M ^{2□}		Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 19,	1941 Penn	nty) isylvania
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				0d. Inside City Limits
	Maryla 1 sho	ō	Maryland Montgomery	100. 01.9, 10 11/10 20	Chevy Chase			ty∑Yes 2 □ No
	r 28a-	Directo	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	ntry?
	deeth with the Maryland ms 23a or 28a-f show r must be rediffed at	al D	4 Spring Hill Court		20815		United S	tates
	er dee itams	Funeral	Arme	Decedent Ever in U.S. 13. \ ed Forces? Yes 2 \ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
22	be filed within 72 hours after deeth with the Marylan had hygiene. Ide Hygiene. Ide other than "natural; or itams 23a or 28a-1 show other than "natural; or itams 23a or 28a-1 show arant, the Madical Examine must be radified at	by	If Ye	s, Give or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	hite
2-003c	72 ho	ompleted	15. Decedent's Education (Specify only highest grade comple	ited) (Give	dent's Usual Occupation kind of work done during most of work	ng 16b	Kind of Business/In Education	
7	within ane. than "	dm		ge (1-4or 5+)	DO NOT use retired)			
2	filed Hygie other ant, II	C	17. Father's Name (First, Middle, Last)	PT P10	fessor of Psycholo 18. Mother's Name	o (First, Middle, Maid	Universit den Surname)	У
Iana		To B	Oscar Starr		Ruth	We	einheimer	
Mary	- C N =		19a. Informant's Name/Relationship (Туре, Print Beth Lichtenstein Sta		ng Address (Street and Number or Rura Spring Hill Court,			Code) 20815
d)	leal leal m 2		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date 20c.	. Location - City or To	own, State
Ē	Pages nent of int: if i		1 ☐ Burial 2 X Cremation 3 ☐ Removal to 4 ☐ Donation 5 ☐ Other (Specify)		- 1 NOV •	004	Beltsvil	le, MD
paltimor	permit. Pages of Department of Hamportant: if its any injury or of ODEs.		21. Signature of Funeral Service Licensee	10 MOS38Z	Name and Address of Facility Rapp Funeral and 933 Gist Ave., S	Cremation	n Services	20910
	•		23a. Part 1. Enfer the disease, or complications to shock, or heart failure. List only one cause	hat caused the death. Do not ent		-	ing, in	Approximate Interval Between
, 1	Physician i	6	Immediate Cause (Final disease or condition		Non Small Cell Lui	ng Cancer		Onset and Death 4 months
	/Medical Examiner		resulting in death)	e to (or as a consequence of):				
		e	Sequentially list conditions, if any, leading to immediate	e to (or as a consequence of):				
	d d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
Š	icate be executed physician and s the burial-transit	Exa		e to (or as a consequence of):				
09/80 08/00	death certificate be executed e attending physician and ad for use as the burial-transit	dical	d.					
מסא	eath certifi attending I for use as	n/Me		s, outcome of pregnancy	75		23d. Date of delive	ery
	death ne atte	hysician/M	1 Yes 2 No		Ectopic pregnancy Other (specify)		Month	Day Year
r Ö	that the de ed by the a detached	Phy	9 Unknown Part II. Other significant conditions contributing		nderlying cause given in Part I	23e Did tobacc	co use contribute to the	ne cause of death?
g,	S L 9	d by PI	, at it.	, 10 001111 011111 011111	nasiying saass giran iir aren		2 □No 3 □ Prob	
Hecords,	ıw require s been siç s should b	ompleted				24a. Wasan	24b. Were auto	psy findings available
	sician: The law certificete has l irector, page 2 s	mo:				autopsy performed 1 ☐ Yes 2 ☑	? death?	mpletion of cause of 2 No
Vital	clan: ertifica actor,	Be C	25. Was case referred to medical examiner?			(Check only one)		
0	this la	T0	1 ☐ Yes 2X No	1 ☐ Inpatient 2 ☐ ER/Outpatier Date of Injury 28b. Time of		me XXResidence 28d. Describe how in	6 Other (Specification)	y)
0	ding Ith. After funer	tlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 Yes 2 No	200. Describe now ii	ijury occurred	
DIVISION	if or Attending P after death. I Diractor: After t d in by the funera	Certification:	3 Suicide 6 Could not be	Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rura	l Route Number,
5	ital or A							
	To the Hospital within 24 hours a To the Funarai I completely filled	edical	(Check only 2 Medical Examiner: On	o the best of my knowledge, deatl the basis of examination and/or in manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as st and place, and due to	tated, the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier.	1	29c. License number	29d. l	Date signed (Month,	
•	1		I finding &	Den NO.	D22775		Nov. 10,	2004
	10		30. Name and address of person who completed Frederick G. Barr M.I			evy Chase.	MD 2081	5
	Sta		31. Date filed (Month, Day, Year)		parks	J		
	Registi	ar	NOV 1 5 2004	- 1 /4	or transferred to the			

State of Maryland / Department of Health and Mental Hygiene 1- Fortal Registra AMEND ITEM #7&19B per fb 8838 97976348 Ref Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day October 27, Physician 2004 William Sterling 4:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner 3200 N. Leisure World Blvd. #716 Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 17, 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Months Days Hours Min. 88 78 Yrs. Maine 226-26-0402 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral', or itams 23a or 28a-f show Exaulter round be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 3200 N. Leisure World Blvd. #716 United States Pages 1 and 2 should be filed within 72 hours after death 1 nent of Heath and Mental Hygiene. int: If item 27 is marked othar then "netural", or itams 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1946-47 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Naval Elementary/Secondary (0-12) College (1-4or 5+) Medical Center Superintendant of Public Works 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sterling Alice Elizabeth Powe11 Ellery Webster 19a. Informant's Name/Relationship (Type, Print) SPRING MD. 20906 Department of Health a Important: If item 27 is eny injury or other trains once. Helen Caraway / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Chesapeake Crematory Nov. 5,2004 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Rapp Funeral and Cremation Services M00382 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD 20910 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebral Vascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the 9 Unknown à ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4√☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nerto certificate XIXNo 1 ☐ Yes Hospital or Attending Physicien: 24 hours after death. Funerel Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 XNatural
2 Accident 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0101235326 November 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hoang An Nguyen M.D.; 201 N. Washington St., Falls Church, VA 32. Registrar's Signature State Registrar

		_	For State Registrar AMEND TIEM 1. Decedent's Name (First, Middle Last)	State of Maryla	nd / Depa	artment of F	lealth and Death		Reg. No.	. 000
	Physicia /Medic	an	1. Decedent's Name (First, Middle Last) Franklin	1011an	arpnack			2. Date of De. Month	Day	Year 11:03 AM
	Examin		4a. Facility Name (If not institution, give s Riderwood Villag			4b. City, Town, or Silv	Location of De	eath	4c. County Mon	of Death .tgomery
	Funeral Director		5. Social Security Number 6. Sex 185-16-1382	7. Age (in yrs	6. last birthday)	If Under 1 Year Months Days	If Under 24 H	Ars. 8. Date of Birl Min. (Month, Da April	27,1918	9. Birthplace (State or Foreign Country) Pennsylvania
	ryland how		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	the Ma	Director	Maryland Montgom	ery		S1.IVe	er Spri		10g. Citizen of W	1 ☐ Yes 2 🖔 No /hat Country?
	ath with 23s or	ral Di	3160 Gracefield R				20904			d States
36	ors after dea al', or Itams	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1577'es 2 No If res, Give Year or Dates: WW	1	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? an, Mexican, Pu Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Race Blac Specify	e - American Indian, k, White, etc. : White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other treumatic event, the Madical Exertinal institution of the rediffical angone.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of d)	working	16b. Kind of Bu	Government
	uld ba filed fental Hygi rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) William Fran	klin Sha	rpnack		18. Mother's I	Name <i>(First, Middl</i> e, be1	Maiden Sumam Woodr	
Mary	d 2 shouth and N	9	19a. Informant's Name/Relationship (Ty) Franklin M. Sharp			ng Address <i>(Street</i> 3 Briars		r Aural Route Numbe	er, City or Town,	State, Zip Code)
Baltimore, Maryland	Pages 1 an lent of Heal nt: If item 2 iry or other		20a. Method of Disposition 1 Burial 2X Cremation 3 R 4 Donation 5 Other (Specify)	20b.	Place of Dispo	osition (Name of matory or other place te Cremato	no No	Date	20c. Location -	City or Town, State
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service License		1382		neral a	nd Cremat: Silver S		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a const	equence of):	ular ular arter des	g, such as care accu yey d nen	dent dent mase hà	rrest,	Approximate Interval Between Onset and Death 2 months
68760,	death cartificate be executed e attending physician and of for use as the burial-transit	dical	resulting in death) Last	Due to (or as a conse	equence of):					
P.O. Box	that the death cartificated by the attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	⊒Ectopic pregnancy □ Other (specify)			23d. Date Mor	e of delivery nth Day Year
	law requires that t as been signad by 2 should be deta		Part II. Other significant conditions con	ntributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.			ibute to the cause of death? 3 Probably 4 Monknown
al Reco	The ate h page	Completed						24a. Was autop perio 1 Yes	prmed?	Vere autopsy findings available trior to completion of cause of leath? ☐ Yes 2☐No
Division of Vital Records,	ttending Physicien: Theath. Beath. tor: After this certificate the funeral director, pag	n: To Be	27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie		er: 4 Norsin	Death (Check only of grand of		
Division	ol or Attending after death. I Director: After d in by the fune	Certification:	1	28e. Place of Injury - At building, etc. (Spe	home, farm, st	M 1 🗆	Yes 2 □ No	28f. Location (S		er or Rural Route Number,
_	lospita t hours unerel	edical Ce	29a. Certifier 1 Pertifying Physical (Check only one) 2 Medical Exami	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the tir evestigation, in my o	ne, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) and mandate and place, a	nner as stated. and due to the cause(s)
)	To the P within 24 To tha F complete	Me	29b. Signature and title of certifier	Humana	1 HD	29c. Licens	e number 5952		NoV	(Month, Day, Year) 8, 2004
	151		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print) PIELD R	OAD,	SILVERS	PRING	, HD 20904
	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 5 2004	32. Registrar's Sig		Ara V				

Roberta Shroyer 04-07195 RPD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physici	all l	1. Decedent's Name (First, Middle, Maria Roberta Zu	Robert	a Shroyer	r		Date of Death Month OVENDE:	r ^D 7, 2004	3. Time of Death 0327 A
/Medic	, ui	4a. Facility Name (If not institution,	give street and nur		4b. City, Town, or Lo			4c. County of Death	<u></u>
		St. Agnes Hospi		7. Age (In yrs. last birthday	Baltimor		Date of Birth	N/A	place (State or Foreig
uneral irector		5. Social Security Number 217–69–2714	.Sex 1□M XXF	25 Yrs.		Hours Min.	(Month, Day, 20)	Year) Cou	intry)
A =		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limit
a-f sho	ctor	Maryland N/A		Baltimore					XXYes 2□N
or 28 De noi	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	-
ns 238	Funeral	1000 Arion Park	12. Was Dece	edent Ever in U.S. 13	Was Decedent of Hisp	panic Origin? (Specif	Yes or No-	hilippines 14. Race - Amer	ican Indian,
od other than "natural", or Itams 23a or 28a-f show to other than "natural", or Itams Ee rolling at event, Ita Medical Evar discrete for Italiad at		1 Never Married XX Marrie	Armed Fo d 1 ☐ Yes If Yes, Giv	2X XNo	If Yes, specify Cuban, XXYes 2□ No	Specify:		Black, White	
tural',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year of D	ates:	edent's Usual Occupati	Fili		As: 6b. Kind of Business/l	
n "na Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College ((Giv	kind of work done dui DO NOT use retired)	ring most of working		lational Fe	
yyleny ner tha t, the	Com		2		lication M	anager 8. Mother's Name <i>(F</i>	0	f the Blin	
ed off	Be c	17. Father's Name (First, Middle, Li Roberto F. Sande				aria Rita		,	
s mark	ို	19a. Informant's Name/Relationshi		19b. Mai	ing Address (Street an				ip Code) 2122
m 27 is		Justin M. Shroye	r (Husbai	ad) 1000 20b. Place of Disp	Arion Park	Road, Apr		Baltimore,	
Department of Heatin and Mental In Importent; If item 27 is marked oth eny injury or other traumatic event once.		20a. Method of Disposition 1 Burial 2XXCremation		State Baltimore	ematory or other place) Crematory Park	Nov, 1	4.		
ortmo orteni injury		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		@ Loudon	Park 22. Name and Address	of Facility Loudo	n Park	altimore, N Funeral H	ome
e de de		23a. Payt T. Enter the disease, or o	arty.			ватті	more,	maryland Z	1229
I bhysician and and and and street stransit and and and and are stransit and and and and and are stransit and and and are stransit and and are stransit and are	dlcal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that intitated events resulting in death) Last	b. Due to	(or as a consequence of): (or as a consequence of): (or as a consequence of):					
ed by the attending p detached for use as t	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼ Unknown	1 Live	nant at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
g	d by Pi	Part II. Other significant condition	ns contributing to c	leath but not resulting in the	underlying cause given	in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to s 2 MNo 3 ☐ Pro	the cause of death
sate has been si page 2 should I	Completed						24a. Was ar autopsy perform 1 X Yes 2	y prior to d	topsy findings availa completion of cause 2 No
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: 1	Inpatient 2X ER/Outpati	Othor	26. Place of Death (nce 6 □Other (Spec	nifu)
th. After this funeral di	tion: To	1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date FOUN		of 28c. Injury a			w injury occurred UN	
within 24 hours after death. To tha Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 □ Suicide 6 X Could n 4 □ Homicide determi	ot be ned 28e. Plac	e of Injury - At home, farm, sing, etc. (Specify) D AT RESIDENCE	street, factory, office	28 BA J	Location (Str City or Town TIMORE	reet and Number of Ru , State) 1000 Å , MARYLAND	RION PARK
a Funer letely fill	edical	29a. Certifier 1 Certifying (Check only 2 Medicel E	xeminer: On the l	e best of my knowledge, de basis of examination and/or nner stated.	ath occurred at the time investigation, in my opi	e, date and place, an nion, death occurred	d due to the ca at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
withir To th compi	Me	29b. Signature and title of certifier	\ h.,		29c. License			od. Date signed (Montl	
) high	i. Mi		O.C.M.	, E .	f	November 7	, 2004
	- 11	30. Name and address of person							

ORIGINAL

			For State Registrar	State of	Maryland /	-	tment of H		nd Mental Hy	giene Reg. No.	004	35947
	Physici /Medic		1. Decedent's Name (First, Middle)		chlesn	cr			2. Date of Do Month	Dey	Year 2004	3. Time of Death
	Examin		4a. Facility Name (If not institution	n, give street and numi	per),		4b. City, Town, or	r Location of			ounty of Death	
		¥ °	Johns Hopk	ins Bay	view		Battimor	re, N	Dacico	8	altimo	sie
	Funeral		5. Social Security Number 213-30-4509	6. Sex 7 1 ☐ M 2 ☑ F	. Age (In yrs. last bi		Months Days	If Under 2 Hours	Min. (Month, D.	ay, Year)		place (State or Foreign ntry)
	Director		Usual Residence of Decedent	- X	69	115.			Dec. 2	4,193	4 West	Virginia
	ow ow		10a. State 10b. County		10c. City, Tov	wn or Loca	ation	<u> </u>			1	0d. Inside City Limits
	Man,	tor	Maryland Ba	ltimore			E	erksh	ire			1 ☐ Yes 2 🖾 No
	J within 72 hours after death with the Maryland jiele. r than "neturel", or Items 23s or 28e-f show The Maxical Examiner must be notified at	Director	10e. Street and Number	_			10f. Zip Code			10g. Citize	en of What Cour	ntry?
	23s	rai	7528 Berkshir	e Road				212			ited St	ates
	tems	Funerai	11. Marital Status	12. Was Deced	es?	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origi In, Mexican.	in? (Specify Yes or N Puerto Rican, etc.)	0- 14	 Race - Americ Black, White, 	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4√∑Divorced	If Yes Give	** ₀	1 [Yes 2500	Specify:		s	Specify:	1
21215-0036	turel	ed		t's Education		a. Decede	nt's Usual Occupa	ation		16b. Kind	d of Business/In	hite _{dustry}
215	C * 3	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4		(Give ki	ind of work done of O NOT use retired	durina most i	of working			,
21	filed withi Hygiene. other than ant, the M	Com	10 Years	January Company		Co	ok			Food	Indust	ry
pu	d in D	Be (17. Father's Name (First, Middle,	Last)					's Name (First, Middle		lumame)	
<u>y</u> la		ို	Alfred Dawso						lah B. Gro			
Maryland	12 s 7 ls reu		19a. Informant's Name/Relations						o <i>r Rumal R</i> oute Numb ad Ba lti m			
	1 an Heall em 2 ther		Brenda L. Schle	sher/Daugh	20b. Place of	of Disposi	tion (Name of	T.	Date		ation - City or To	
no	0 0		1 Burial 2X Cremation 4 Donation 5 Other (S		ate	-	itory`or other plac		1 /0 /2004			
altimore,	- 돈만 등		21. Si nature of Funeral Service		HILLEC	22.	Name and Addres	ss of Facility	1/9/2004		son, Ma	*
ã	Depar Impo eny ir		Me. (Can	00	Du 79	da-Ruck	Funer	al Home of Dundalk,	Dund Marvla	lalk, In and 21:	C. 222
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that car	used the death. Do							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Vie	ntricu	lar	film	Mat	700			Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consequence	of):						
	LAdilliller	L.	Sequentially list conditions,	b. Due to /o	r as a consequence	1	Artery	DI	sease			
_	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	\$ 200.00	as a consequence	I.D.	- 1					
<u> </u>	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (o	r as a consequence	e of):						
8760,	The faw requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit											
9	rtificat ng phy as th	Physician/Medicai	PETALLE.								,	
Вох	eath certific attending p for use as f	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ome of pregnancy th 2 Fetel deat	th 3 □E	ctopic pregnancy			23	d. Date of delive	
.O.	at the dea by the at tached fo	sici	1 Yes 2 No 9 Unknown	4□Pregna 9□Unknov	nt at time of death	5 🗆 (Other (specify)				MOTH	Day Year
Ω.	that the		Part II. Other significant condition	ons contributing to dea	th but not resulting	in the unc	derlying cause give	en in Part I.	23e, Did	tobacco use	e contribute to the	ne cause of death?
ds,	uires tha signed Id be de	d by		3			, ,		1 🗆	Yes 2	No 3 ☐ Prob	ably 4 Unknown
Records,	w requ been should	Completed							24a. Was	an	24b. Were auto	psy findings available
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Vital		0	25. Was case referred to medica	1				26. Place of	1 ☐ Yes of Death (Check only	2 No No	1 🗆 Yes	2□ No
₹ <	y s	To B	examiner? 1 □ Yes 2 💢 No	Hospital: 1 X In	patient 2 ER/O	utpatient	3□ DOA Othe	er: 4 🗆 Nurs	sing Home 5 Res	idence 6	Other (Specify	y)
n of			27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date of (Month		Time of Injury	28c. Injury Work	/ at	28d. Describe			
Sio		cati	2 Accident investi	gation				Yes 2□N				
Division	I or Attending after death. Director: After I in by the fune	Certification:	4 Homicide determ	lined 200. Flace	of Injury - At home, f g, etc. <i>(Specify)</i>	tarm, stree	et, factory, office		28f. Location (City or To	Street and wn, State)	Number or Rura	il Route Number,
J	Hospitel 24 hours a Funerel I itely filled		29a. Certifier 1X Certifyii	ng Physician: To the b	est of my knowledg	ge, death o	occurred at the tim	ne date and	place, and due to the	cause(s) a	nd manner as st	ated
	To the Hospitel within 24 hours and the Funerel I completely filled	edicai	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examination a	ind/or inve	stigation, in my or	pinion, death	occurred at the time,	date and p	lace, and due to	the cause(s)
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifie		00 1	17	29c. License	e number		29d. Date	signed (Month.	Day, Year)
	M		Julia	Jua	cle, r	110	RES -	000		Nover	mber le	, 2004
	")		30. Name and address of person	who completed cause			nnt)					
			Julie J. Scia		4940 Eas	tern	Ave. B	altimo	ore, Maryla	ana 2	21224	
et.	Sta Registi		31. Date filed (Month, Day, Year,	2004	gistrar's Signature	1	. 26 .					
34	ricgist	φH		100	was so	1400	EL)					

Physician Journal Country Country (Country Cou				For State Registrar	State	of Maryla		partment of Fertificate of		and Ment	al Hygie	/ 11111	1	35948
Examiner 4. Facility Name of row inclusion, you street and miningery 5. Seed about your street and miningery 6. Courty of the part of t						1	1				ate of Death		ır	3. Time of Death
South House To See and Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							SKI	1		No		r 11 200	04	0550 M
Second Secretary Numbers Second Secretary Numbers Second Secretary Numbers Second Secretary Numbers Second Secretary Numbers Second Secon		Examin	er				relater					4c. County of De		A
Disclored Proposed Pr		Funeral			6. Sex	7. Age (In y		y) If Under 1 Year	If Under 2	24 Hrs. 8. Da	ate of Birth	9. 8	Birthpla	ce (State or Foreign
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20b. Pleace of Disposition (James of Date 20c. Location - City or Town, Scientific Court of Town	ryla	hould id Mer marke matic	ြ				19b. Ma	iling Address (Street					e, Zip C	Code)
Column C		d 2 th a tra				Husband						-		
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	30X	ith cert tendin or use	an/N	23b. Was decedent pregnant			etal death		у					
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The part of Death of the Color of Death of the Color of Death of D	tal	en: Ti tificate tor, pa	e C	25. Was case referred to medica	al				26. Place			No 1 LY	es 2	.□ No
The property of the property o		nysici nis cer I direc	.0		Hospital: 1	Inpatient	2 🗌 ER/Outpat	ient 3 DOA Oth	¹er: 4 ☐ Nui	rsing Home	5 🗌 Residenc	e 6 □Other (S	pecify)	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, You have and address of person who completed cause of death (Item 23a) (Type, Print) Mirielle Meyerhoefer MD 4940 Eastern Avenue, Both more 1 ND 21224			lon:	1 Natural 5 ☐ Pend	ng (A	ite of Injury fonth, Day Yea	r) 28b. Time	/ Wo	rk?		Describe how	injury occurred		
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Mirielle Meyerhoefer MD 4940 Eastern Avenue, Baltimore, ND 2122				M. Wley	erhuefo	n Mi	PW		3785	5	11	11/04		
24 Date filed (Afrath Day Year) 22 Pagistrar's Signature		\mathbb{O}_{i}					(Item 23a) (Typ 4940	e, Print) Eastern	Aveno	ve, B	altimo	re, ND	212	204
Registrar NOV 1 5 2004 Service & Sparky				31. Date filed (Month, Day, Year NOV I	5 2004 3:		ignature					,		

Examiner

Medical Certification; To Be Completed by Physician/Medical

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene important; in Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Exercise must be notified at once.

To Be Completed by Funeral Director

Pnysician /Medical

State Registrar	d Item 29	d per Dr.	, G837, IE	ertifica	004dhi	ealth and N Death	Mental Hyg R		14	35949
. Decedent's Name ((First, Middle, Last)						2. Date of Deat	th		3. Time of Death
James	E. Slevi	n. Sr.					Nov. 2,	Day 2004	Year	11: 25P ^M
. Fecility Name (If n				4b. Ci	ty, Town, or	Location of Death		4c. County	of Death	1 2 2 2 2
Stella	Maris Ho	ospice			Time	onium		F	Balt i r	nore
Social Security Nur	nber 6. Sex	7. Age	a (In yrs. last birthda	y) If Uno	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			elece (State or Foreign etry)
14-14-366 sual Residence of D	3	M 2□F	90 Yrs.	IVIONIN	Days	riodis Mill.	July 7,	1914		W York
a. State	10b. County		10c. City, Town or	Location					16	0d. Inside City Limits
MD	Harfor	rd	Fores	t Hil	.1					1 □Yes 2 🗓 No
De. Street and Numb				10f. Zip Code 10g. Citizen of Wi						itry?
1606 Cre	ston Dr.			21050 USA						
. Marital Status		12. Was Decedent E Armed Forces?	Ever in U.S. 13	3. Was De	cedent of His	· -	pecify Yes or No-	14. Rac	e - Americ	
1 Never Married	2 X Married	1 X Yes 2 □ N	lo		2 X No	Specify:	o , noan, ott.)			
3 Widowed 4	□Divorced	If Yes, Give Year or Dates:	43'-45'		, EM1140	эр в спу.		Specify	v: Whit	ce
(Specify	5. Decedent's Edu only highest grade	e completed)	(Gi	ive kind of	sual Occupa work done di Luse retired)	urina most of worl	king	16b. Kind of Bu	usiness/Inc	dustry
Elementary/Second	ary (0-12)	College (1-4or 5 N/A		w Yor	k City	y Police	Officer	Law E	nford	cement
7. Father's Name (F	irst, Middle, Last)						ne (First, Middle, M			
Michael R	obert Sle	evin				Anna Bi	urke			
9a. Informant's Nam			19b. Ma	ailing Addre	ess (Street a		ral Route Number	, City or Town,	State, Zip	Code)
Eileen A.	Slevin/V	Wife	160	6 Cre	ston I	or. For	est Hill	MD 21	050	
		lemoval from State	Dulaney Memorial	Valle Gard	or other place	110 7 01	mber 6,	20c. Location -		
1. Signature of Eune	S rvice Licens	99			10111			Timon		
10	Mici	iael J. F	lagle	Lemmo 10 W.	n Fune Pador		e of Dula Timoni			
23a. Part1. Enter the shock, or heart	disease, or compli	ael J. F	the death. Do not e		and Address n Fune Pador	s of Facility eral Home nia Road	e of Dula Timoni	aney Va um, MD		Inc. Approximate Interval Between
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State

DHMH 17 Rev 1/2001

NOV 1 5 2004 Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

2300 DULANEY VALLEY RD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

29c. License number

29d. Date signed (Month, Day, Year)

November 3, 2004

	Amena rtem J	per court order, gogo, 10/05/09dilb	
DALE STEVENSON	For Unpend Item	23ac27 per me G838 12-2-04 tas Certificate of Death	Hygiene 001
	Docietana	Gertificate of Death	Dog No.

3 5	TEVENS	SON	State Offperid Trem		aryland De r me G838	partment of t ertificate of	lealth and M Death			
	Physici	an	Decedent's Name (First, Middle, La	,				Date of Deat Month	Day	Year 3. Time of Death
	/Medic		Dale Ardin Steve		-			NOV.	11, 200	
9.5	Examir	er	4a. Facility Name (If not institution, giv 5006 ARABIA AV)	, ,	or Location of Death		4c. County	of Death
					no (la usa la sé bisébul		MORE CITY If Under 24 Hrs.	0. Date of Birth		0.00
	Funeral Director		217-44-3404-	M 2□F	ge (In yrs. last birthde 58 Yrs	Months Days		8. Date of Birth (Month, Pay, 1/16/19	946	9. Birthplace (State or Foreig Country) Maryland
Pare	*		Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			10d. tnside City Limit	
prepared of the Mach	or items 23a or 28a-f show	ō	MD N	'A	Baltime	ore			1≹Yes 2□N	
tho a	28a	Director	10e. Street and Number			10f. Zip Code	10f. Zip Code			What Country?
	Sa or	ā	5006 Arabia Aver	nue		2121	4			S.a.
loan	ns 2	Funeral	11. Maritat Status	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of I		ecify Yes or No-		e - American tridian,
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ויסמוס מוופו		þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify	" White
2	"natural", olical Ext	Completed	15. Decedent's E	ducation	16a. De	cedent's Usual Occu	pation		16b. Kind of Bu	usiness/Industry
=	- 1924	pie	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or	5.4)	ve kind of work done DO NOT use retire		ing		
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D :	tal Hygiene. d othar than evant, II.e M	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	Maiden Sumam	ne)
ed Ding		To E	E. Earl Stevenso	n			Jane	Carmich	nael	
5	th and Mental 7 is marked of treumetic ev		19a. Informant's Name/Relationship (Type, Print) Mary Jean Stevenson/Wife 19b. Mailing Address (Street and Number or Rural Route) 5006 Arabia Avenue Baltimo:						-	· ·
2	f Health a itsm 27 i								Maryla	nd 21214
	Department Important: any injury once.		*4 Donation 5 Other (Special Signature of Funeral Service Lice	Ragui	t	6415 Bela	ess of Facility Mi ir Road B	ller-Dip altimore	pel Fur , Maryl	re, Maryland neral Home Inc land 21206
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death cettill	the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetat death	3 □Ectopic pregnanc 5 □ Other (specify) _	ey		23d. Dat Mo	te of detivery nth Day Year
וואמווואס ווושו וווא	ped ed	þ	Part II. Other significant conditions	contributing to death	but not resulting in the	e underlying cause gr	ven in Part I.	23e. Did tob		ribute to the cause of death? 3 Probably 4 Unknow
THE IAM FULL	has b	Completed	L					24a. Was al autops perform 1 2 Yes 2	y ned?	Were autopsy findings available prior to completion of cause of teath? Yes 2□No
	certificate rector, pag	e e	25. Was case referred to medical				26. Place of Deatl			
rnysician.	S .E	To B	examiner? 1X Yes 2 ☐ No	Hospital: 1 Inpati	ient 2 ER/Outpa	tient 3 DOA Ot	har	me 5 Reside		er (Specify) AT SCEN
	Affei une	ation: T	27. Manner of Death 1 Natural '5 Pending 2 Accident Investigation	28a. Date of Inj (Month, Da	ury 28b. Time ay Year) tnju	y Wa		28d. Describe ho		A A ST THE PART OF
6	after death. I Diractor: After	Certification:	3 Suicide 6 Could not to determine determined	28e. Ptace of tri building, e	njury · At home, farm, tc. <i>(Specify)</i>	street, factory, office		28f. Location (St. City or Town	reet and Numb n, State)	er or Rural Route Number,
	4 hours Funaral	edical C	29a. Certifier 1 Certifying P. (Check only one)	hysician: To the best miner: On the basis of and manner s	of examination and/o	eath occurred at the trinvestigation, in my	rme, date and place, opinion, death occurr	and due to the cared at the time, da	ause(s) and ma ate and place, a	inner as stated. and due to the cause(s)
1 THB	within 24 h To tha Fur completely	Mec	29b. Signature and atte of certifier	And mariners		29c. Licen	se number	2:	9d. Date signer	d (Month, Day, Year)
٠	동물용	1		/ 1/	1		C M T			

₹ 29b. Signature

O.C.M.E

NOV. 11, 2004

ed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)
NOV 1 5 2004

. Registrar's Signature

Amend Item 25 per Verb., C837 II 115/2004 bb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28,2004 **Physician** Month Peggy A. Wyman October 9:50 /Medical 4b. City, Town, or Location of Death Dundalk 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) **Examiner** Genesis Heritage N.H. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 3 (Month Day Year) 9. Birthplace (State or Foreign Funeral 213-36-7248 1□M XXF 62 Maryland Director Yrs. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at Md. Baltimore Director 1X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3230 Barclay Street 21218 USA 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give* Year or Dates: "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after c Hygiene. other then "natural", or Iten 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 3 ☐ No þ 3- Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If Item 27 is marked other than 37 is marked other than any injury or other treumstic event. Nursing Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Green Helen Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Prince 1219 Ashland Ave. Balto. Md. 21202 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemerty 11-5-04 Woodlawn, Md. 21. Signature > Figural Survive License 22. Name and Address of Facility 1639 N. Broadway Balto. Miller's Metropolitan Chapel P.C. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. the attending physician by Physiclan/Medicai the as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dinknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 No 1 Yes 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) Registrar's Signature State Registrar

			1 - For State of Maryland / Departme Certifica	nt of Health and Mei te of Death	ntal Hygien	.004	35952
			Decedent's Name (First, Middle, Last)	2.	Date of Death Month Da		3. Time of Death
	Physici /Medic		JEROME WITHERSPOON, SR.		11 10		620AM
	Examin			y, Town, or Location of Death	40	c. County of Death	
	·			SALTIMORE er 1 Year If Under 24 Hrs. 8.	Date of Righ	N/A	and (State of Comics
	Funeral Director		243.50.497 150M 20 F 72 Yrs. Months	Days Hours Min.	Date of Birth (Month, Day, Year,	32 Counti	ace (State or Foreign MD
	D.		Usual Residence of Decedent				
	arylar show	-	10a. State 10b. County 10c. City, Town or Location BALTIMO	ne.		10	d. Inside City Limits 1 Yes 2 No
	the M 28a-f	ectc		ip Code	100 (itizen of What Countr	
	with Ba or	Ö	331 N. EDGE WOOD STREET	21229	109.01	U.S.A	
	death	Funeral Director		edent of Hispanic Origin? (Specify ecify Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - America	
9	atter or Ita		1 Never Married 2 Married Armed Forces? If Yes, sp 1 XYes 2 No If Yes, Give 1 ∨ Yes	5 4	an, etc.)	Black, White, et	
21215-0036	be filed within 72 hours atter death with the Maryland that Hygiene. ad other than "natural", or Itams 23a or 28a-f show ovant, the Medical Examinating the notified at	d by	3 DXWidowed 4 Divorced Year or Dates:				, 0, -
15-	in 72 i "nat	Completed	life, DO NOT	rork done during most of working	16b. K	and of Business/Indu ANCHOR	•
212	filed with Hygiene. Ither than	mo	Elementary/Secondary (0-12) 12-H1 Oracle NIA TRI	UCK DRIVER	M		REIGHT
	should be filed withir nd Mental Hygiene. marked other than imatic evant, the M	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maider	1 Sumame)	
<u>yla</u>	2 should be and Mental Is marked of aumatic eve	2	Fred Witherspoon	Sarah	· McCr	ay	<u></u>
Maryland	2 8 8 2			ss (Street and Number or Rural R			
	of Health itam 27 other tr		Terome Witherspoon, JV. 20b. Place of Disposition (N.	ame of Date		ocation - City or Tow	MD 21212 m. State
nor	0 = 5		1 B⊞urial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	other place)	1	INGS MI	
Baltimore,	artm orta	П	21. Signature of Funeral Service Licental 22. Name a				
ä	Depar Impor any ir		Pangh C+	BALTIMORE NA	T'L PIKE	LEERVICE BALTOIN	ID 21279
			23a. Part 1. Enfact he disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.			í	Approximate Interval Between
	Pnysician	į g	Immediate Cause (Final disease or condition VENTRICULAR	ARRHYTHMI	A	(Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
	- yer	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events C.				ļ.
o`	an an	Еха	resulting in death) Last Due to (or as a consequence of):				
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical	d				
9	entific ding p	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
Вох	eath certific attending p	clan	in the past 12 months?			23d. Date of delivery Month	/ Day Year
P.O.	tt the de by the a	Physician/Me	1 Yes 2 No 9 Unknown	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	es that igned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
rds	w require been sig should b	ted t	CHRONIC REMAL FAILURE		1 ☐ Yes 2	□No 3□Probat	bly 4 ⊠Unknown
Vital Records,	e law r has be je 2 sh	Completed	STAPHYLOCOCLUS SEPSIS		24a. Was an autopsy	prior to comp	sy findings available pletion of cause of
<u>~</u>	: The l	Con	LARYNGIEAL CANCER		performed? 1☐ Yes 2⊠No	death? 1 ☐ Yes 2	M No
Vita	ysician: This certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (C			
o	Phys rrthis aral di	To It	1 Yes 2 No Prospital 1 Inpatient 2 ER/Outpatient 3 D 27. Manner of Death 28a. Date of Injury 28b. Time of		5 🗷 Residence . Describe how inju		
ion	nding Fath. r: After e funera	ation	1 ⊠Natural 5 □ Pending (Month, Ďaý Year) Injury 2 □ Accident investigation M	Work? 1 ☐ Yes 2 ☐ No			
Division	for Attsno after death Diractor:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office 28f.	Location (Street ar City or Town, State	nd Number or Rural F e)	Route Number,
	nital or urs afte ral Dir lled in	Cer		1			
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: Atter this cartifica	edical	29a. Certifier (Check only one) 1	d at the time, date and place, and n, in my opinion, death occurred a	due to the cause(s at the time, date and) and manner as stat d place, and due to t	ted. he cause(s)
	o the ithin of the omple	Med		9c. License number	29d. Da	ite signed (Month, Da	ay, Year)
	->-0		Navnet Kour Aluja, M.D.	D61824	1	1-15-0	04
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAVNEET KAUR AHUJA; HARBOR HOSPITA	L CENTER, 300	I S. HAN	10 VER ST,	, BALTIMOR
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 5 2004 32. Registrar's Signature	rk/			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 004 35953 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 09,2004 522 M BERTHA LEE WASHINGTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Samaritan Hospita Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03 17 34 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Days Hours 213-32-6105 F1Yrs. Director 70 Usual Residence of Decedent Maryland 10b. County 10c. City. Town or Location 10a, State 10d. Inside City Limits ir then "neturel", or items 23a or 28e-f shovers. Wedical Examinar must be notified at 1 ☐ Yes 2X No Directo Baltimore Parkville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 49 Mercury Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Black 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Geriatric Nursing 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should ba fi Beatrice Griffin Herman Lee Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is rr any injury or othar treum 2002. 49 Mercury Ct., Parkville, Md Marvin Washington-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 11/16/04 Randallstown 21. Signature Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final disease or condition resulting in death) LUSS **Physician** ACUTE BLOOD /Medical Due to (or as a consequence of): Examiner RUPTURE OF ARTERIOVENOUS FISTULA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death cartificate be executed Due to (or as a consequence of): Box 68760, Physiclan/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, RENAL 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2DNo o the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this After this funeral of 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Vithin 24 hours are Vithin 24 hours are To the Funeral Dir 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier abithHa D51135 NOVEMBER 10 2004 VVO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELIZABETH HALLORAN, MD. BLVD BALTIMORE RAVEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 08:53 AM Ophelia Womack NOVEMBER 10. 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORG JAMARITAK If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 □ F 219-16-4141 26,1915 89 South Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other traumetic event, the Medical Examiner inval be notified at XXYes 2⊡No N/ABaltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1102 Druid Hill Avenue Apt.913 21217 UsA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify. è 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private family 6th grade Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ophelia Goodman Henry Truesdale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 19a. Informant's Name/Relationship (Type, Print) 3616 W. Saratoga St. Baltimore, Maryland Lillian Coleman /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 11/16/08altimore, Maryland ₩ Burial 2 Cremation 3 Removal from State Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Fwheral Service Licenses Hari 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** MYOCARDIAL INFARCTION /Medical Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medlcal Due to (or as a consequence of) 23b. Did tobacco usa contribute to tha cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ QOA 1 Yes 2 No မှ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 27. Manger of Death 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No

Examiner physician and s the burial-transit The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, attending ph certificate hes been signed by the a lirector, page 2 should be detached Hospital or Attending Physician: funeral director, this After efter death.

Director: Aff
d in by the fur within 24 hours eft

To the Funerel Di

completely filled in

death with the Maryland

altimore, Maryland 21215-0020

Certification:

Medical

5 ☐ Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch RAVEN GOULEVAR)

TERRANCE L. BAKER MD BALTIMORE, MARYLAND 21239

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 35955 For State Registra Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** A^{M} 13, 6:46 Clare Wilson White November 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Oct. 18, 19) Montgomery Suburban Hospital 9. Birthplace (State or Foreign Country)
Illinois 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 83 Yrs. Director 330-16**-**3277 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Bethesda Maryland Montgomery the the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 9809 Holmhurst Road 20817 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? filed within 72 hours after 1 ☐ Never Married 2 Married 1⊠Yes 2 No If Yes, Give Year or Dates: WW II ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) National Institutes Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) of Health Administrator other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othnany injury or other traumatic event size. Be Earl Francis White May B. Headley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9809 Holmhurst Road, Bethesda, Maryland 20817 Eileen C. White/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 17, 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park Rockville, Maryland 2004 4 ☐ Donation 5 ☐ Other (Specity) Robert A. Pumphrey Funeral Home/Chase, Inc. 21. Signature of Funeral Service Licensee M00198 7557 Wisconsin Ave., Bethesda, MD 20814-3501 Approximate Interval Between Onset and Death 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician ATHORD SCLINGSIN CADIOURSCULMS mymm /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duá to (or se a consequanca or) Examiner Due to (or as a consequence of) Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ FVOutpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death tnjury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident Could not be 3 🗀 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 401 Name and address of person who completed cause of death (Item 23a) (Type, Print) RD O'BRIEN 8600 20814 ocall Jan N 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NUV 1 5 2004 Registrar

		1	For State Registrar	State of	of Maryland	d / Depa <i>Cei</i>	artment of F tificate of	lealth an Death	d Mental Hyg	jie 2 e00 L	35956
	.		1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		Velma	Mary	Porter	We	ese			er 8, 2004	6:10 P M
	Examin		4a. Facility Name (If not institution				4b. City, Town, o		Death	4c. County of Dea	
			7424 St. Patr	icia Cou 6.Sex	rt 7. Age (In yrs. Ia	and to instruction of	Dund If Under 1 Year		Hrs. 8. Date of Birth	Baltin	NOITE CO.
	Funeral Director		5. Social Security Number 220–16–6694	1 ☐ M 21 F	7. Age (iii yis. ia	Yrs.	Months Days		Min. (Month, Day	Year) C	implace (state of Foreign country) ryland
			Usual Residence of Decedent						OCC. 4,	1327 146	rytand
	how		10a. State 10b. County	D = 1 + 1		, Town or Lo	cation	Dund	_ 11_		10d. Inside City Limits
	Se-f s	Director	Maryland	Baltimo	re						1 ☐ Yes 2X No
	vith th	Dire	10e. Street and Number				10f. Zip Code	0.00		log. Citizen of What C	,
	s 236	era	7424 St. Patrio		edent Ever in U.S	3 13 1	Was Decedent of H	2122		United S	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23e or 28e-f show or other treumatic event, the Medical Examinat must be notified at or other treumatic event, the Medical Examinat must be notified at	by Funeral	1 Never Married 2 Marr	Armed F	orces? 2√∑No ive		fYes, specify Cuba 1□Yes x [X]No	an, Mexican, P Specify:	? (Specify Yes or No- Puerto Rican, etc.)	Black, Wh	
o o	2 hou ature	ted	15. Deceden	's Education		16a. Dece	dent's Usual Occup	ation	6 - 4	16b. Kind of Busines	
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Maryland 21215-0036	be filled that the doth	Be	17. Father's Name (First, Middle,						Name (First, Middle,		
<u>\Z</u>	2 should to and Ment Is marked	10	John Edgar P 19a. Informant's Name/Relations			10b Mailir	a Address (Street		e Mae Wrig		Zin Code)
Mai	d 2 st th and t7 Is n treur	H S	Mrs. Clara Bel		ghter		•		ct. Dundal		' '
ക്	Health tem 27 lother tree		20a. Method of Disposition	_ /	20b, Pf	ace of Dispo	sition (Name of matory or other place	201	Date	20c. Location - City o	r Town, State
OE .	Pages ent of nt: If I		XXBurial 2 ☐ Cremation		State	-	-		/13/2004	Middle R	iver, MD
Baltimore,	permit. Pages. Department of h Importent: If Ite any injury or of		21. Six ature of Funeral Service		10		Name and Addre Duda-Rud	ss of Facility ck Fune	eral Home	of Dundalk	, Inc. 21222
		4	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death	. Do not ent			Dundalk, rdiac or respiratory arr		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(3)	WILL (. 1	lung	diceris		Onset and Death
	/Medical		resulting in death)	a	(or as a consequ			10117	1130001		
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	xecut and	Examiner	that initiated events resulting in death) Last	c	(or as a consequ	ence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical E		d							
9	as as	ledic			-	-					
Вох	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnar		Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
.O. E	ne dea the at hed fo	/sici	in the past 12 months? 1 Yes 2 No	4□Preg 9□Unk	nant at time of de nown	eath 5	Other (specify)			MOUTH	Day
Θ.	requires that the reen signed by th hould be detache		Part II. Dther significant condition	ons contributing to	death but not resu	Ilting in the u	nderlying cause giv	en in Part I.	23e. Did to	baccouse contribute	to the cause of death?
ds,	w requires that s been signed t should be det	d by	Congestive	Heart	Failu				180>	s 2 No 3 F	robably 4 Unknown
Records	> 10 (1)	Completed	Altheime	ט טע	le ment	19			24a. Was a	an 24b. Were a	utopsy findings available
Re	e la has	duic	77.000000						autops perfor	med? death?	completion of cause of
Vital	icien: Th certificate rector, pag	a	25. Was case referred to predica					26. Place of	1 ☐ Yes Death (Check only or		5 21110
Ţ	d is	To B	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2 🗆 E	ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursi	ng Home 5 Reside	ence 6 Other (Sp	ecify)
n of	ng Ph áter th ineral		27. Manner of Death 1 ■Natural 5 □ Pendir	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time o Injury	Wor	k?		ow injury occurred	
sio	Attending ir death. ector: After by the fune	catl	2 Accident investi	gation				Yes 2 □ No		to a to and the same and the	Control Northean
Division	of or Attence after death Director:	Certification:	4 Homicide determ	ined 200. Place	e of Injury - At ho ding, etc. (Specify	me, rarm, sti	eet, factory, office		City or Town	treet and Number or F n, State)	rurai Houte Number,
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.								place, and due to the c		
	the Ho hin 24 h the Fu npletely	edical	one)	and ma	basis of examinat nner stated.	ion and/or in			occurred at the time, d		
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	1			29c. Licens	e number 1 399		29d. Date signed (Mor	nth, Day, Year)
			77	7		00-1		!		1.90	Γ
	10		30. Name and address of person Theodore Steph			23a) (Type, North	Pt. Blvd	. Suite	e 724 Balti	imore, Mar	yland 21224
	Sta Registi		31. Date filed (Month, Day, Year)		legistrar's Signat						

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Da}12, 2004 **Physician** MARGARET LOUISE WAGNER November 11:45 am /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Holly Hill Manor If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
January 27, 1907 6. Sex 9. Birtholace (State or Foreign **Funeral** Months 1 □ M 2 □ F 97 Director 212-36-0234 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Ext. itrer : sust be notified at Baltimore MD n/a 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 W. Belvedere Ave., Apt. M2 21215 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, Ite Manical Ext., Item 1 and 000. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a Office Manager Business school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary John Tyson Hood Jane Cookingham ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. Buckner-daughter 6008 Winthrope Ave., Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corporation 11/15/04 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 21. Signature of Funeral Service License William G. Dau 5305 Harford Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician archoma month, disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the first indexing Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) the 9 Unknows signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 Tyes 2 No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature an itle of certifi 29c. License number 7-1704 NOVEMBER 12,2004 completed cause of death (Item 23a) (Type, Print) of person who LEAVEY, MARC M.D., 1205 YORK ROAD, LUTHERVILLE, MARYLAND, 21093 31. Date filed (Month, Day, Year) legistrar's Signature State NOV 1 5 2004 Registra

04-07121	Please Type or Print in Black Indelible Ink. Ensure A	All Copies Are Legible.	
Joseph Michael RJD	Allen State of Maryland / Department of Health and 1- For Amend Item 1&Unpend Item 23a, 27, 28a-f per me G83 Certificate of Death	Mental 1470 47248 () L	3595
Physician		2. Date of Death Month Day Year November 3, 2004	3. Time of Dear

Center

4b. City, Town, or Location of Death

Examiner

Director

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital

Funeral Director

the Maryland al Hygiene.

27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Event, not must be notified at death v Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 marked o itam 27 Department of H Important: If its any injury or ot once.

> Physician /Medical Examiner

physiclan and s the burial-trans use as t ed by the a detached f signed t been signature cate has t Hospital or Attending Physician: this After death. Director: 24 hours e Funaral

2

Certification:

Division of Vital Records, P.O. Box 68760.

The law requires that the death certificate be

8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months 1**X** M 2□ F 32 Yrs. 578 98 9878 1972 July 11, Washington, DC Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County DC Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20002 1719 Lang Place, NE United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Social Event Planner Convention Center 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph M. Allen Sr. Gloria Gaskins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2902 Sand Creek Way, Forrestville, MD Joseph M. Allen Sr./Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 11/11/2004 Bladensburg, MD ` 4 ☐Donation 5 ☐ Other (Specify) 21. Senature of Juneral Service Licenses 22. Name and Address of Facility John T. Rhines Funeral Home 3015 12th St., NE Washington, DC 23a. Part1. Enter the disease, or complications that caused is shock, or heart failure. List only one cause on each line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Gunshot Wound To Head disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, loading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Clue to for as a consequence off Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 N Homicide 29a. Certifier

Yes 2 No

examiner'

25. Was case referred to medical

5 Pending investigation 6 Could not be

Scene

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury Found h, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Found

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 🕱 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

Subject Was Shot 28f. Location (Street and Number or Bural Route Number, City or Town, State) 6707 Governors

Bridge Road, Bowie, Md

2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) November 4, 2004

4c. County of Death

Prince Georges

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

1 Yes 2 □ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

0 9 2004

Registrar DHMH 17 Rev 1/200

State

within 2

			For State Registrer	State of N	Maryland / D	-	rtment of Herificate of L		d Mental	_	ne 0	04	359	59
			Decedent's Name (First, Middle, Last)							of Death	Day	Year	3. Time of	Death
	Physicia /Medic		Marcia Allison						0ctc	ber	23^{Day} , 20^{Day}		4:10	а м
	Examin	er	4a. Facility Name (If not institution, give sti				4b. City, Town, or Chevy Ch		Death		4c. Count Montg	y of Death		
	Funeral		Brighton Gardens at 5. Social Security Number 6. Sex		Age (In yrs. last birth	nday)_	If Under 1 Year_	If Under 24		of Birth			place (State of	r Foreign
	Director			M 2₹1 F	95 Y	rs.	Months Days	Hours N	Dec.	13,1	908	Utah	ntry)	
	DUR M		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation					1	0d. Inside Cit	v Limits
	f sho	Į.	MD Montgomery		Chevy C								1Ž∑Yes	
	r 28e-	Director	10e. Street and Number				10f. Zip Code			100	. Citizen of	What Cour	ntry?	
	23a o		5555 Friendship Blv	'd•			20815				SA			
	tems	Funeral	11. Walkar Olalos	2. Was Deceder Armed Force	s?	13. W	as Decedent of His Yes, specify Cubar	spanic Origin' n, Mexican, P	? (Specify Yes uerto Rican, e	or No-		ce - Americ ack, White,		
50	I's afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2% If Yes, Give Year or Dates		1	□Yes 2K□No	Specify:			Specia	^{fy:} Whi	te	
213-0030	be filed within 72 nours after death with the Maryland to Hygiene. do other then "neturel", or items 23a or 28e-f show event, the Madral Examiner must be notified at	ted	15. Decedent's Educa	ation	16a. I	Decede	ent's Usual Occupa	tion	funding	16	ib. Kind of E			
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	111111 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-40	r 5+)		ind of work done d O NOT use retired)	uring most ar	working					
7	e tiled with al Hygiene. I other ther vent, It's V		17. Father's Name (First, Middle, Last)		H	lome	maker	18 Mother's	Name (First, I		Own He			
		o Be	Wilford W. Christen	sen					Hunsal		iden ouma	moj		
37	2 should be to and Mental His marked of reumatic eve	To	19a. Informant's Name/Relationship (Type				Address (Street a	nd Number o	or Rural Route	Number, C		, State, Zip	Code)	
Ma Ma	and 2		Douglas Steele Theu	rer - s	300		Colton L	n., Da	rnestov	vn, M	D 20	878		
Baitimore	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Re	moval from Sta	20b. Place of cemetery	Disposi , crema	ition (Name of atory or other place	9)	Date	20	c. Location	- City or To	wn, State	
	t. Pag rtment rtent:		`4 ☐ Donation 5 ☐ Other (Specify)			ill	Cemetery	Nov	7.6, 20)
מ	Departing any in sonce.	. 6	21. Signature of Funeral Service Licenses		5		Name and Address 30 Wiscon		_			ons 11 0016	nc.	
			23a. Part1. Enter the dease, or complice shock, or heart failure. List only one	ations that caus	sed the death. Do no								Approximate Interval Bety	e e e e e e e e e e e e e e e e e e e
	hysician		Immediate Cause (Final disease or condition		Failure								Onset and C 2 year	Death
	/Medical Examiner		resulting in death)	_	as a consequence o	f):								
	LAdiminer	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		ar Diseas							-		
	uted 3 ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0.1										
oʻ	an and	Exa	resulting in death) Last	Due to (or a	as a consequence o	f):								
8/60,	death certificate be executed e attending physician and id for use as the burial-transit	dlcal	d.											
OX P	eath certific attending p	/Med	IF FEMALE: 23	c. If ves. outcon	ne of pregnancy						22d D	ate of delive	200	
n	seath atten	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant	2 Fetal death at time of death		Ectopic pregnancy Other (specify)					onth	,	'ear
		hys	9 Unknown	9□ Unknown	1									
<u>'</u>	20 00	by P	Part II. Other significant conditions cont	ributing to death	n but not resulting in	the und	derlying cause give	n in Part I.	23e				ne cause of do	
cord	w require been si	eted												
ď)	The law ate has b page 2 sl	Completed							24a	 Was an autopsy performe 		prior to condeath?	psy findings a mpletion of ca	available ause of
		e Co	25. Was case referred to medical					26 Place of	Death (Check] No	1 🗆 Yes	2 No	-
	> 0 0	O B	eyaminer?	spital:	atient 2 ER/Out	patient	3□ DOA Othe		ng Home 5		ce 6 □Oti	her (Specif	y)	
n or	± = =	on: T	27. Manner of Death 1X Natural 5 Pending	28a. Date of Ir (Month, I	njury 28b. Ti Da <i>y Year)</i> In	ime of ijury	28c. Injury Work	at ?	28d. Des		injury occu-			
DIVISION	Attendi death. ctor: A y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	28e Place of	Injury - At home, fan	m stree		′es 2 □ No	-	tion (Stre	et and Num	her or Rura	I Route Num	ber
	after after Direct d in by	Certification:	4 Homicide determined	building,	etc. (Specify)	, 5110	ot, raciory, omos			or Town,		0.0.110	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	301,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier Certifying Physi (Check only 2 Medical Exemine	cien: To the be	st of my knowledge,	death	occurred at the tim	e, date and p	place, and due	to the cau	se(s) and m	and due to	tated.	
	the H hin 24 the F nplete	Medical	one)	and manner	stated.		29c. License				l. Date signe			
	Wit Co	-	29b. Signature and title of certifier	H B	le w		D2355				tober			
	4		30. Name and address of person who com	pleted cause of	of death (Item 23a) (Туре, Р	rint)	·						
			Rober Blee, M.D.		isconsin A			Chase,	MD 20	0815				
	Sta Registi		31. Date filed (Month, Day, Year) OCT 28 200		strar's Signature	9	Sparks	4						

Laura Adkins 04-6934 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 35960 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vasi **Physician** ADKINS October 26, 10:57 A^M LAURA LYNNE 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign Cumber 1 and
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Memorial Hospital 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 X F Months 46 216-70-1534 APR. 13,1958 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral', or itams 23a or 28a-f show 1 ☐ Yes X☐ No Directo ALLEGANY RAWLINGS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21557 LOT 27-BLOOMINGFIELDS DRIVE, SW U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I've Medical 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. ASSISTANT SOCIAL WORK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be markad HOMER FRANKLIN ADKINS DOREMUS MAE DAVIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21557 itam 27 TIFFANY O'BRIEN / DAUGHTER P.O.BOX 115 RAWLINGS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 10/30/2004 CUMBERLAND CREMATORY CUMBERLAND, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that gused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Errie. Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) o the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 🗌 Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2 🗆 No Yes 2 No Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**○**ER/Outpatient 2 1 ☑ Yes 2 ☐ No 3□ DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 No Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To tha Funaral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated the 29d. Date signed (Month. Day, Year) 29c. License number 29b. Sigr 2 October 27, 2004 O.C.M.E. cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 State

Registrar

outs)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For Stata Ragistra 35961 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October **Physician** 2004 8:40 A M Ardinger Frances Corinne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hagerstown

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year)
June 14, 1924 Washington Clearview Nursing Home 9. Birthplace (State or Foreign Country) Mary I and 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 80 219-14-8400 Director Usual Residence of Decedent 10d. Inside City Limits ba filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2CXNo Directo Fairplay Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21733 16750 Spielman Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced White "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) itam 27 la markad o permit. Pages 1 and 2 should ba Department of Health and Mental Important: If flam 27 Is marked 4 any injury or other traumatic events. ၉ Raymond Jacobs Frances Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16750 Spielman Road Fairplay, Maryland <u> Larry Ardinger - Son</u> 20a. Method of Disposition

1 Deurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State `4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park Nov.2,2004 Williamsport, Maryland 21. Signature of Funeral Service Licens Osborne Funeral Home, P.A. 21795 425 S. Conococheague St. Williamsport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure Physician /Medical Due to (or as a consequence of): Examiner Metastatic Ovarian Cancer unknown Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consumence of) Examiner To the Hospital or Attending Physician: The law raquires that the death certificate be exacuted the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760 physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Multiple Ischemic Infarctions of Brain 24a. Was an autopsy performed? 1 ☐ Yes XX No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No page 2 s 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4XXVursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: Division Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death n 24 hour. tha Funaral Dirac. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) al D0058181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 382 S. Cleveland Avenue Hagerstown, Maryland 21740 K. Peprah, M.D. 31. Date filed (Mont/Nov/ 1 2004 32. Rigistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 35962 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last 10/23/2004 **Physician** Alvey 9:35 P Grace /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Bradford Oaks Nursing & Rehab. Center Clinton 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/08/1912 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2 🖾 🛣 Months Washington, DC 578-24-2823 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State show ral', or items 23a or 28a-f shov Exertible fourthe notified at 1 Yes 2 XXIVo Completed by Funeral Director Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other then " any injury or other trauments." 7520 Surratts Road 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전域o If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married White 1 ☐ Yes 2 TNo Specify: Specify: 3 XXVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Steele William Waple 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 671 North Beach, Maryland Theresa McGraw / Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XX remation 3 Removal from State 10/26/2004 Edgewater, Maryland Kalas Crematory * 4 □ Donation → Other (Specify) 22. Name and Address of Factorge P. Kalas Funeral Home FA 21. Signature Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAPDIOVASCULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 🗌 Unknown 2 been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2XIXNo certificate 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2XXXVo 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by hours after 4 Momicide hin 24 hours at XXertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 0 person who completed cause of death (Item 23a) (Type, Print) 12070 OUD LINE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item # 3, per MD, G838 12/23/04 TT
State of Maryland Department of Health and Mental Hygiene 0 0 1 35963 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Day **Physician** 26, Karen Louise Akers October 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year Months Days If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1□M 2XF 10/10/1947 Washington, DC 215-54-5312 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 1 ☐ Yes 2 X No Director Rockville MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18110 Cashell Road 20853 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Editor U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emma Louise Atterberry William Asbury Akers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10118 117th Place, NE, Kirkland, WA 98033 Shirley A. Raabe, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☑ Conation 5 ☐ Other (Specify) Ft. Lincoln Crematory 10/27/2004 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the dise se, or complications that crust of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPATHY 36 HR. Due to (or as a consequence of): VENTRILLIAR FIBRILLATION 36 MR. Due to (or as a consequence of): Examiner ALUTE MYOCARDIAL INFARCTION 36 MA.

Physician /Medical **Examiner**

death certificate be executed

Division of Vital Records, P.O. Box 68760,

or Attanding Physician:

after death

To the Hospital within 24 hours a To the Funeral I.

Funeral

Director

itiam 27 is marked other then "natural", or itams 23e or 28e-f show other traumatic avant, the Medical Examinar must be notified at

h and Mental F 7 is marked of

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Itam 27 Ia marked any injury or other traumatic avence.

e filed within 72 hours after death val Hygiene.

Other then "natural", or Itams 23e

Baltimore, Maryland 21215-0036

with the Maryland

use as the burial-tra Physiclan/Medlcal been signed be should be det ģ Completed page 2 Be 2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

DIABETES

STALE

Due to (or as a consequence of): ZSIHEMIL 23c. If yes, outcome of pregnancy Live birth 2 Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

HEART

23d. Date of delivery Month Dav

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DISEALE

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XUnknown

24a Wasan 1 Yes 2**X** No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

10 DAYS

Year

25. Was case referred to medical examiner? Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No

investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

RENAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DESEASE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a, Certifier (Check only one)

an shew of or

29c. License number 023630

29d. Date signed (Month, Day, Year) OCTOBER 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16220 FREDERICK RD #213, GAITHERS BURG, MA 20877 FRANK J. MAYE. .40

Registrar

10

Certification:

31. Date filed (Month, Day, Year) OCT 27 2004

32. Registrar's Signature Deneva

Amend item#29c, perform G837, 11/15/04TT State of Maryland / Department of Health and Mental Hygieper Olys 35964 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** SAHITI MINUMULA BODE AKHILA 1253 M Nov 6 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL BALTIMORE NIA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 4 | Oct. 2, 2004 CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□M 2□F Director unk Maryland Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at Maryland Montgomery Silver Spring 1 Tes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14109 Castle Blvd., #102 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural; or Item any injury or other traumatic event, the Medical Examinations. Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Asian 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) O child none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Venu Bode Sujatha Minumula 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Venu Bode -father 14109 Castle Blvd., #102 Silver Spring, Md.20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Md. National Mem.Park 11/9/2004 | Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NECROTISING ENTEROCOLITIS 6 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PREMATURITY SUSPECTED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed the attending physician and ned tor use as the burial transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 an/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year Physici 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tyes 2X No 3 Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 X No 1 Yes 1 Yes or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 1 Yes 2 XNo Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide within 24 hours a

To the Funeral E

completely tilled Hospital 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NOV, 6, 2004 P18656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAJEDA KAMALVDDEEN, Wivesity Maryland Medical center 22, s. Greene St, Baltimore, MD21201 31. Date filed (Month Day, Year) 32. Registrar's Signature State مساحه عارة مايون مثليل Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER Day 5, 2004 **Physician** ELEANOR B. BRYNER 7:22 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ST. VINCENT de PAUL NURSING CENTER **FROSTBURG** ALLEGANY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year) | Aug 21, 1920 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 218-16-4532 Director 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show 27 is marked other than "natural", or items 23a or 28e-f shov treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 538 National Hwy 21502 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a any injury or other treumatic event, Iha Madicial Examinations once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Fiber/Textile Bobbing Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar William Bryner, Sr. Marion Elizabeth Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 LaVale Terrace, LaVale, MD 21502 Diane Lehr-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Rose Hill CemeteryNov 6,2004 Cumberland, MD 21 Signature of Funera (Service Licensee 22. Name and Address of Facility Hafer Funeral Service PA 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately County (Single) Approximate Interval Between Onset and Death Alzhimen Immediate Cause (Final **Physician** disease or condition resulting in death) Sycurs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi attending physician and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ Mo this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident atter death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 058353 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRANTSVILLE, MD DR, 32 CORPORATE CHOTANI 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			1 - For State Registrar		State of	Maryla		artment of F <i>rtificate of</i>	leaith and i <i>Death</i>		giene Reg. No.2	004	35966
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	/Medic	al	4. 5. 10. No. 2. 16. A. 1. 10.		ERT	D.	BI	DDLE	-1	Octobe	er 28	, 2004	0515 ^M
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Maryland 21215-0036	2 should and Men Is marke sumatic	Γ_{i}	19a. Informant's Name/Relat		уре, Print)		19b. Maili	ng Address (Street	and Number or Ru		er, City or To	own, State, Zip (Code)
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ary shoul and M s mari umati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street ar				State, Zip (Code)
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Itimore, Maryland 2 Itimore, Maryland 2 It. Pages 1 and 2 should be filed from the Hilled Mental Hyg right: If item 27 is marked other injury or other traumatic event.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State		natory or other place,)	111	20c. Location -		
Baltimore, Maryland 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene, Insportant: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumatic event, the Mexical Examination and process.	ŕ	` 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Green A		10-30		alisbu	ury,N	/d.
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chel		30. Name and address of person who completed cause of de	2		- **		1	100	
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Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maxical Exactine must be notified at any injury or other traumatic event, the Maxical Exactine must be notified at any once.	by Funeral	1 Never Man	ried 20Married 4 Divorced	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		1 ☐ Yes		Specify:	erto Mic	an, etc.)	- 1	-	hite, etc. Black	
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Maminus and physician and particular it ansit to a set the burial-transit	al Examiner	Sequentially list of any, leading to cause. Enter Und Cause (Disease of that initiated even resulting in death)	onditions, mmediate erlying r injury ts	Due to (or a Due to (or a C. Due to (or a d.	s a conseq	uence of):									
	Physician/Medic	IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	nt pregnant 2 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3[⊒Ectopic ⊒ Other (s					2	3d. Date of Month	delivery Day	Year
ac d	by	Part II. Other sign	ificant conditions co	ontributing to death	but not res	ulting in the u	ındərlying	cause give	n in Part I.			obacco us Yes 2 [e to the cause of	f death?]Unkno
signed by t Ild be detach	ete										24a. Was autop perfo 1 Yes		24b. Were prior death		s availa cause
ate has been sign page 2 should be	Completed								26. Place of D	eath (C	heck only o	one)			
ate has been sign page 2 should be	C	25. Was case refe						OA Othe	4 Nursing	Home	5 √ Resid	dence 6	Other (S	Specify)	
is certificate has been sign director, page 2 should be	O	examiner?				ER/Outpatie	nt 3 🗆 🗆								
n. After this certificate has been sign funeral director, page 2 should be	To Be C	examiner?	No ath 5 Pending investigation	28a. Dale of In	jury	ER/Outpatie 28b. Time o Injury		28c. Injury Work		280	. Describe t	how injury	occurred		
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			For State Registrar	State of Ma	ıryland		artmen rtificat			ind M	_	giene		359	69
	Physici		1. Decedent's Name (First, Middle, Last, MARION A. BARNES)							2. Date of De Month OCT •	Day	2004 Year	3. Time of 0	Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	f Death	001.		County of Death	ZALI	
	CAUTIII		Salisbury Nursing	and Rehab	Cente	er			Salis	bury	, Md.	W:	icomico		
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. las		If Under Months		If Under 2		8 Date of Bir	th Year)	9. Birthr	lace (State or htry) KLYN, N	Foreign
	Director		038-01-8306	□M 211 F	92	Yrs.	141041613	Days	110013		07-14-	1912	BROC	KLYN, N	.Y.
	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							0d. Inside City	Limits
	Aaryli r sho	ច			•									1X Yes	
	ous after death with the Marylan ral', or items 23a or 28e-1 show Exeminer must be notified at	by Funeral Director	MD WICOM I 10e. Street and Number	LCO	FRUI	TLAND	10f. Zip	Code				10g Cit	izen of What Cour	itry?	
	Sa or	0	407 FOREST DRIVE				101124	0000	2182)6		. og. om	USA	,.	
	death	era	11. Marital Status	12. Was Decedent E	ver in U.S.	13. \	Was Deced	lent of Hi			cify Yes or No Rican, etc.))-	14. Race - Americ		
9	or ite	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give	0					Puerto I	Rican, etc.)		Black, White,	etc.	
5-0036	72 hours after death with the Maryland Inatural; or Items 23e or 28e-f show dical Examiner must be neitified at		3 ₩idowed 4 Divorced	Year or Dates:			1 □ Yes 2	ZAJ NO	Specify:				Specify: WH	ITE	
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CA	Hygie Hygie other		17. Father's Name (First, Middle, Last)			П	OMEMA	KEK	18. Mother	's Name	(First, Middle		OWN HOME	·	
an	d be ental ked o	To Be	THOMAS VICTORY						HELEN				,		
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other than eumatic event, Ine M.	-	19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailin	ng Address	1_				er, City o	r Town, State, Zip	Code)	
	and 2 ealth a m 27 le		JUNE LENOX - DAUGH	HTER		407 F	OREST	DRI	VE, FR	RUITI	LAND, M	IARYL	AND 2182	6	
ore,	ges 1 and 2 should be filed within 72 hc tof Health and Mental Hygiene. If item 27 le marked other than "natur or other treumatic event, Ite Modeal		20a. Method of Disposition	Computal from State	20b. Plac	ce of Dispo	sition (Nan	ne of ther place	a)	D	ate	20c. Lo	cation - City or To	wn, State	
Ë	Pages nent of I ent: If its ury or o		1X Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		MORA	VIAN	CEMET	ERY	10	-30	-2004	STAT	EN ISLAN	D, N.Y	•
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licens	88	1	22	. Name an	d Addres	s of Facility	BOU	JNDS FU	NERA	L HOME,	INC.	
	40 E 8 9		Mussa for	1 Janes	7								,MARYLAN		4
	Physician /Medical		23a. Part. Enter the disease of compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Ceret	the death.	O-		e of dying		cardiac of	r respiratory a	rrest,	-	Approximate Interval Betwood	een eath
	Examiner			4		en	100	5						2 677	
	n =	ner	Sequentially list conditions, if any, leading to immediate	Due to fr as a	conseque	nce of):									
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8760	physi the b	dlcal		d.											
Вох 6	death certific e attending p id for use as	by Physician/Me	in the past 12 months?	23c. If yes, outcome of 1 Live birth 24 Pregnant at	2 ☐ Fetal de	eath 3	Ectopic pro					2	23d. Date of delive	ry Day Ye	ar
0	that the death ed by the atte detached for	Jysh	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				,,							
Θ,	requires that the een signed by th hould be detache	y PI	Part II. Other significent conditions con	ntributing to death bu	t not resulti	ng in the ur	nderlying ca	ause give	n in Part I.		23e. Did t	obacco u	se contribute to th	e cause of dea	ath?
Records,	w require been sig should b	ed t									1 🗆 '	Yes 2[□No 3 □ Prob	ably 4	rknown
CO	> _0 v	Completed									24a. Was		24b. Were auto	sy findings av	/ailable
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Vital	sicien: certifica rector, p	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
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	ding P n. After t funera	on:	27. Manner ✓ Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 21	8b. Time of Injury		8c. Injury Work			8d. Describe I	now injury	y occurred		
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Division	al or Attendated after death	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At nomi . (Specify)	e, rarm, stre	et, factory	, office		2	City or Tov		d Number or Rura)	Houte Numbe	9 <i>r</i> ,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Pertifying Phy. (Check only one) 2 Medical Exami	sicien: To the best of ner: On the basis of and manner stat	examination	edge, death n and/or inv	occurred a	at the time in my op	e, date and inion, death	place, a	nd due to the d at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	11			29c	License	number			29d. Date	e signed (Month, I	Day, Year)	
			200 /H	Lun			5)	28	34	08	10	1/28/69		
		5	30. Name and address of person who co		ath (Item 2	За) (Туре, І	Print)	20	0 0:	ic *	VO 55	liah.	17°17 M.J	21004	
	(1	L)		M, 2016	\mathcal{O}	Ů.		20	O CTA	TC A	ve.,5a.	TISDI	ury, Md.	21004	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 6 2004	32. Registra	s Signatur	<i>y</i> ,	Spar	les							

DHMH 17 Rev 1/2001

MARIAN BARNES

State of Maryland / Department of Health and Mental Hygien 0 0 1 35970 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Elizabeth Bozman October 29, 8:15 AM M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11190 Messick Road Dames Quarter Somerset If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 0 F Director 220-28-0899 86 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, The Madical Eventhreat the Indiffect at 2008. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director MD Somerset Dames Quarter 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11190 Messick Road 21821 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes. Give Specify: Specify: 3 ☐ Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Messick Mary Messick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorilee Dunn/Daughter 11190 Messick Road, Dames Quarter, MD 21821 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition
1 Seurial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Dunn Bozman Cemetery 10/31/2004 Dames Quarter, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed burial-transit the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ e Q 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has or Attending Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification; To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after deal To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide the Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print) 145 E. 14) inmy laylor, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

NOV 0 3 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla		artment of Heal rtificate of Dea		Hygiene 0	104 35971
	Physici	an	1. Decedent's Name (First, Middle,	(1)	cl	1.1.00	Mont		3. Time of Death
	/Medio	cal	LAROLYN M 4a. Facility Name (If not institution,		7 PBU -	MARD 4b. City, Town, or Local		ober 28,	2004 0332 a ^M
	LXaiiiii	ICI	30717 West Post			Princess A			merset
	Funeral Director		207-56-9401	. Sex 7. Age (in yrs	34 Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min. 8. Date (Mon	of Birth th, Day, Year) 09-70	9. Birthplace (State or Foreign Country) PA
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	peation			10d. Inside City Limits
	Ba-fsh	ctor	MD Some	RSET T	Cinces:	Anne			1 ∑Xes 2 □ No
	ath with the 23a or 2	Funeral Director	30717 West Pa	of office RI		10f. Zip Code 2185		u	of What Country?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or Items 23a or 28a-f show stry injury or other traumatic event, the Medical Examble in util be instiffed at ance.	by	11. Marital Status 1 Never Married 25 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2★ No If Yes, Give Year or Dates:	ĺ	Was Decedent of Hispanie of Yes, specify Cuban, Me 1 ☐ Yes 2 1 No Spe			Race - American Indian, Black, White, etc. acify: Black
15-(n 72 h r "natu edical	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b. Kind o	f Business/Industry
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Maryland	should nd Mer marks	T _o	Jeo Pa E Calvin			ng Address (Street and No	→		wn, State, Zip Code)
	1 and 2 Health a am 27 Is		Arthony E. W.	, , , , , , , , , , , , , , , , , , , ,			t-office R	o Prince	:ss Anne No 21853
Baltimore,	ages 1 nt of He : If Itan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, crei	sition (Name of matory or other place)	Date		on - City or Town, State
äţ	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li			U.M.C. Cemoler			well, MD
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			23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final						Approximate Interval Between Onset and Death
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68760,	tificate be executed g physician and as the burial-transit	edical	•	d					
Вох 6	death certifi e attending d for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		Ectopic pregnancy		23d.	Date of delivery
Ю.	ires that the death cer signed by the attendin d be detached for use	Physician/M	in the past 12 months? Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Month Day Year
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ords	w requires been sig should be	ted b						1 ☐ Yes 2 No	3 ☐ Probably 4 ☐ Unknown
Records,	e law has b	Completed						Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death?
Vital F	(0	e Co	25. Was case referred to medical			26 0	lace of Death Check of	es 2□No	1 No 2 No
of Vi	Physiclan: this certific ral director,	To B	examiner? 1X Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpatien	Other			Other (Specify) at scene
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Division	l or Attending after death, Diractor: After	Certification:	2 Accident investiga 3 Suicide 6 Could no determin	be 28e. Place of Injury - At I	03:20 home, farm, str		28f. Lant	ion (Street and Nu	mber or Run I Route Number,
ā	ital or irs afte ral Diri		4 Homicide	building, etc. (Spec	RASIA		Post o	Fle, Pris	LESS ALME, MD
	To the Hospital or Attending Physician: whim 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director, completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying (Check only one) Medical E:	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	nowledge, death ation and/or inv	occurred at the time, date restigation, in my opinion,	e and place, and due to death occurred at the t	the cause(s) and ime, date and plac	manner as stated. e, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	110		29c. License numb	ber		ned (Month, Day, Year)
	<i>(</i>)		- 1000	lah Hi		OCME		Octobe	er 28, 2004
	9		30. Name and address of person w ZABIG CCAI	o completed cause of death (Ite	m 23a) (Type,	111 Penn	Street, Ba	ltimore,	Maryland 21201
1	Sta	_	31. Date filed (Month, Day, Year)	32. Regularar's Sign	nature	1-			

State of Maryland / Department of Health and Mental Hygien 2 0 0 1 35972 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician ERNEST RAYMOND BARLOW JR. October 28 2004 8:20 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince George's Cheverly Prince George's Hospital If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F 1937 Washington, DC 577-50-3983 Director 67 August Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow ral, or items 23a or 28a-f ahov Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo S.Dakota Pennington Hill City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12559 Ford Mountain Court 57745 U.S.A by Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after de if Hygiene. other than "natural", or Item Armed Forces Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes. Give 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If item 27 Is marked other th
any injury or other traumation. 12th Glazer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Ernest Raymond Barlow Sr. Catherine Evelyn Mock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Barlow / Wife 12550 Ford Mountian Court Hill City S. Dakota 57745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mountian View ceme 11/2/04 Rapid City S. Dakota 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Road Landover, Maryland 20785 a 23a. Part1. Enter the dreas shock, or heart falure. ease, or complications to s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se peach line. Immediate Cause (Final disease or condition emo **Physician** resulting in death) /Medical u-lo (or as a consequence of) withis Jong Discos Examiner me Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ♣ No certificate 2 🔯 No 1 🔲 Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 1X Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident investigation death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ō Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and txte of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Catevenia M.D. 3001 Hospital Drive Cheverly, Maryland 20785 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H			giene 0 0	4	35973
	Physici /Medic		Decedent's Name (First, Middle, PEARL	Last) BAGLEY	***************************************		-	2. Date of Dea Month OCTOBER	th Day	Year 004	3. Time of Death 1:40a M
	Examir		4a. Facility Name (If not institution, Southern Maryla	-			r Location of Dea inton		4c. County	of Death	
	Funeral Director		5. Social Security Number 579 28 0375 Usual Residence of Decedent	6. Sex 7 1 ☐ M 2 ☑ F	Age (In yrs. last birthday) 94 Yrs.	Months Days	If Under 24 Hrs Hours Min		Year) 1910	Cou	place (State or Foreign http:) Th Carolina
	r 28a-f show	Irector	10a. State 10b. County	George's	10c. City, Town or L	Marlboro		1	0g. Citizen of V		10d. Inside City Limits 1 Yes 2 No
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is merked other than "natural", or Items 23a or 28a-f show or other traumatic avent, the Medical Examinant must be indiffied at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force	s? No	20772 Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Blac	e - Americk, White,	-
21215-0036	filed within 72 ho Hygiene. Ither than "natur ant, the Madical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 8th	Grade completed) College (1-4c)	(Give life.	dent's Usual Occup e kind of work done DO NOT use retired	during most of wo		16b. Kind of Bu	<i>r</i> ate	dustry
land	ld be fil ental H ked oti ic aver	To Be	17. Father's Name (First, Middle, L Willie Barber	ast)				_{me (First, Middle, .} nie Gunth		10)	
Maryland	2 should be fi and Mental H is marked of	-	19a. Informant's Name/Relationsh			ng Address (Street	and Number or R	ural Route Number	, City or Town,		
Baltimore, №	Party		Lucy R. Barber- 20a. Method of Disposition 1 Spurial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from Sta	20b. Place of Dispondentery, cre White Oak	matory or other plac Bapt. Cl	nurch Cei	Date 1-6-04 n.	20c. Location ·	City or To	own, State South Carolina
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service	, Busca	-Towc 4	2. Name and Addre 308 Suit	ss of FacilityMa: Land Road	rshall's d Suitlar	Funeral	Hom	e of MD
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or can shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or b)	ed the death. Do not en	ter the mode of dyir thon Yena		c or respiratory arr		V	Approximate Interval Between Onset and Death
,8260,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):						
.O. Box 6	The law requires that the death certifics to has been signed by the attending proage 2 should be detached for use as II	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify) _	,		23d. Dat Mor	e of delive	ery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant condition	ns contributing to death		Inderlying cause giv		23e. Did tol	5.00		ne cause of death?
of Vital Records,		Completed	<u> </u>	y perto	nsim			24a. Was a autops perforr	y ned? d	Vere auto prior to cor leath?	psy findings available mpletion of cause of 2 \sum No
ion of Vita	nding Physician: Th uth. r: After this certificate e funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 Po 27. Manner of Death 1 Ratural 5 Pending investige			f 28c. Injur Wor	er: 4 Nursing F	ath (Check only on dome 5 \subseteq Reside 28d. Describe ho	ence 6 Othe		1)
Division	al or Attandii s after death. Il Director: A sd in by the fu	Certification;	3 Suicide 6 Could no 4 Homicide determin	200. Flace of	njury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Numbe 1, State)	er or Rura	I Route Number,
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune.	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner	st of my knowledge, deat of examination and/or in stated.	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	a, and due to the caurred at the time, d	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)
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K	()		30. Name and address of person was a second of the second	Pautel, u	10. 750	Print) 1 Syr	rents R	d. eli	nton.	m	020735
	Sta Registr		NOV 0 1 20		strar's Signature	de la					

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER **Physician** 6:50 P 27 2004 WADE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2212 Vermont Avenue Prince Georges Landover 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 □ F Yrs. 215-02-8526 Director 36 April 17 1968 Penn. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or itams 23s or 28a-1 show traumatic avant. The Medical Examinar must be notified at 1√2Yes 2□No Director MD Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2212 Vermont Avenue 20785 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ∰No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ Specify: **Black** 3 ☐ Widowed 4 ☑ Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12th Electrician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fill if Health and Mental H itam 27 Is markad ott Be Clarence E. Byrd Paulette Reddy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Byrd/Brother 1307 Aragona Blvd Ft. Washington, Maryland 20744 itam 27 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. = 5 Brentwood, Maryland Lincoln Cemetery 11/3/04 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that fell is shock, or heart failure. List only one cause on each line. The reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infraction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying iner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No jo Day 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown End Stage Renal Disease Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No Cardiomyopathy page 2 s 1 Yes 2 ☑ No Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: မှ 1 🗌 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After or Attanding 1 🛮 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) filled 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00053107 10/29/04 Sul Nit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sanil Nath M.D. 14300 Gallant Fox Lane # 205 Bowie, Maryland 20715 31. Date filed (Month, Day, Year) NOV 0 1 2004 State Registrar

Gerrardo Gutierrez Barilla Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 4 unknown 04-352 35975 1 - For State Registrar 04-6959 Certificate of Death DOS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 2018 p^M Gerardo Gutierrez Barillas October 27, 2004 4c. County of Death /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 11130 New Hampshire Avenue Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Yrs. Director El Salvador 1946 None Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itame 23a or 28a-f ehov other treumstic event, the Macheal Examinar must be notified at 1X Yes 2 □ No Maryland Prince George Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ā 8102 15th Avenue, #201 20783 El Salvador death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 🖺 Yes 2□ No Specify: El Salvadorian Specify: Spanish Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☎ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finand Mental His marked of Olivia Barillas Ismael Gutierrez ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health and ent: ff Item 27 Is r Jose A. Gutierrez/Brother 8102 15th Avenue, #201; Hyattsville, MD. 20783 20c. Location - City or Town, State E1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State ō permit. Page Department of Importent: ff any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Jeneral Cemetery 4,2004 De Ahuachapan, Salvador Nov. Pope Funeral Homes 11315 Lockwood Drive Silver Spring, MD. 21. Signature of Functial 6 rvice License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head death. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Contact disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by sign d be No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 1 X Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) at SCENE 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 10/27/04 М Su 5 death. 8:10 Director: 2 Accident 6 Could not be 3 Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Rocie Number of Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Mor rechir 5-freet A 24 hour. 11130 New Houshire AVE, limity 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of o ertifier 29c. License number 29d. Date signed (Month, Day, Year, OCME October 28, 2004 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MID JACK M 31. Date filed (Month, Day, Year) Registrar's Signature State 0 2 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		/ Department of Health and M Certificate of Death	-
Physician /Medical Examiner	Decedent's Name (First, Middle, Last) RICHARD ALAN BECK 4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER	4b. City, Town, or Location of Death	2. Date of Death Month Day Year OCT 22 2004 8:55 A M
Funeral Director	5. Social Security Number 232-70-5488 192M 2 F 58 Usual Residence of Decedent	BETHESDA st birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) PA . 9. Birthplace (State or Foreign Country) PA .
with the Maryland e or 28e-f show be nutified at		Town or Location urrells Inlet	10d. Inside City Limits 1 절 Yes 2 □ No
ath with the s 23e or 2 live to a 10 live	10e. Street and Number 6431 Somersby Dr.	10f. Zip Code 29576	10g. Citizen of What Country? USA
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other tran "neturel", or Items 23e or 28e-f show eny injury or other treumatic event, the Modical Experiment multilled appres. To Be Completed by Funeral Director	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: 7 / 1 /	2/63 If Yes, specify Cuban, Mexican, Puerto	ncity Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 ed within 72 hours aft ygiene ygiene rthan "neturel", or erthan "neturel", or t, the Medical Exam Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 +	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Managemer	
Maryland 2 nd 2 should be filed thand Mental Hygi 27 is marked other remmatic event, I	17. Father's Name (First, Middle, Last) Karnie Spratt	18. Mother's Name Opal F	(First, Middle, Maiden Sumame) Richmond
re, Mar 1 and 2 sho Health and tem 27 is m other treum	19a. Informant's Name/Relationship (Type, Print) Richard T. Beck/Son 20a. Method of Disposition 20b. Pla	19b. Mailing Address (Street and Number or Rura 12071 Linda Pl. Mar ce of Disposition (Name of netery, crematory or other place)	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any injury or other page.		nesapeake Crem, 10/2	27/04 Beltsville,Md. FUNERAL SERVICE,P.A.
icate be executed Walking physician and physician and sthe burial-transit and policial Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque c. Due to (or as a conseque d. Due to (or as	nce of):	Interval Batween Onset and Death
the death certif	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ර සම් පු වි	Faith, Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕱No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☒ No
On of ding Phys After this funeral did	27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 2 Accident investigation		(Check only one) ne 5 Residence 6 Other (Specify) 8d. Describe how injury occurred
S parie T	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)		8f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attanctum 24 hours after death To the Funeral Director: Completely filled in by the Medical Certificat	29a. Certifier 1 Certifying Physician: To the best of my knowle (Check only only) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	29c. License number	d at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
15	30. Name and address of person who completed cause of death (Item 2 LINDSAY E. JONES LT MC USNR		AVAL MEDICAL CENTER ED 20889-5600
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	" & Sparks	

			1 - For State Registrar				of Health and of Death	Reg	one 004	35977
	Physic		1. Decedent's Name (First, Middle, Last) ADELATDE]					2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give 2216 Glen Cove Roa	street and number)			m, or Location of Deal		2 9. 2004 4c. County of Deal Harfo	h
	Funeral Director		5. Social Security Number 6. Set 215-68-7421	7. Age	(In yrs. last birthday 47 Yrs.		ear If Under 24 Hrs ays Hours Min.		1957 Ma	hplace (State or Foreign untry) ryland
	h the Maryland r 28a-f show	ō	10a. State 10b. County Maryland Harfo	ord	10c. City, Town or L	ocation Darlin	ort on		,	10d. Inside City Limits
	with the 3a or 28a-	I Director	10e. Street and Number 2216 Glen Cove			10f. Zip Cod		10g	. Citizen of What Co USA	untry?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show evant, the Midles Exartire must be nuitiled.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Pes 2 N N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
Maryland 21215-0036		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Oc kind of work do DO NOT use re	one during most of wo etired)	rking 16	b. Kind of Business/	
ryland;	2 should be filed and Mental Hygis Is marked othar aumatic evant, II	To Be C	17. Father's Name (First, Middle, Last) William Tildon, S				18. Mother's Nar Bessie	ne (First, Middle, Ma Fields	00	
	l and lealth im 27 har tr		19a. Informant's Name/Relationship (Tyr.) Vita Banks / daugh 20a. Method of Disposition	•		Glen Co	ove Road,	Darlington	, MD 2103	4
Baltimore,	t. Pa rtmen rtant: njury		1 ☐ Burial 2 【X Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		R.A. Fer	matory or other ris & Co	o., Inc 1	1/1/04 W	c. Location - City or lest Chest	
Ba	Depa Impo any is		Des Scientification of Pulleran Science Liberts	cit	2	Lisa So 552 Lev	ddress of Facility Cott Funera Wis Street	al Home, P	A. Grace M	n 21079
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	the death. Do not enep. consequence of):	ter the mode of	dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. if yes, outcome o	Petal death 3	JEctopic pregna			23d. Date of delik	rery Day Year
P.0.	at the de by the a tached t	hysic	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	4 □ Pregnant at t 9 □ Unknown	ime of death 5	Other (specify	")		WOTE	Day rear
Records, F	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	ρ	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause	given in Part I.	23e. Did tobaca 1 ☐ Yes	co use contribute to	the cause of death?
Vital Reco		Completed						24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of 2 No
Division of Vit	ling Phys T. After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatien 28a. Date of Injury (Month, Day	28b. Time of	28c. 1r	O++	th (Check only one) ome 5 & Residence 28d. Describe how in		fy)
Divis	To the Hospital or Attanowithin 24 hours after death To the Funaral Diractor: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y · At home, farm, str (Specify)	eet, factory, offic	се	28f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
	To the Hospital or within 24 hours afte To the Funaral Dir. completely filled in I	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	ixamination and/or inv	occurred at the restigation, in m	e time, date and place, ny opinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	stated. the cause(s)
>	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	1, MD			ense number		Date signed (Month,	
			30. Name and address of person who con	10 (ath (Item 23a) (Type,	Print) Pluern	Chesas	he this	ce Elk	1,2004 ton MD
	Sta Registra		31. Date filed (Month, Day, Year) NOV 0 1 200	32. j egistrar	s Signature	ale		11 4	,	-, -

3	> Clicu			2	-	560 24		toher 28	
Medical	(Check only 2! Medical E.	xaminer: On the best xaminer: On the basis of and manner st	f examination and/	or investigation	d at the time on, in my op 9c. License	oinion, death occ	e, and due to the cause(: urred at the time, date an	nd place, and due	e to the cause(s)
Medical Certification;		28e. Place of In building, et	ury - At home, farn c. (Specify)		ory, office		28f. Location (Street a City or Town, State	te)	
tion: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga			ne of	28c. Injury Work		28d. Describe how inju		***
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ¶o	Hospital: 1 Inpati	ent 2 ER/Outp	atient 3 [Othe Othe	ac.	ath (Check only one) Home 5 - Residence	6 ☐Other (Spe	cify)
luneral director, page z snould							autopsy performed? 1 ☐ Yes 2 ☐ N	prior to death?	completion of cause
leted t							1 Ves 2		robably 4 Unkn
leted by Physic		s contributing to death b	out not resulting in t	he underlying	cause give	en in Part I.	23e. Did tobacco	use contribute to	o the cause of death
ior use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal death	3 □Ectopic 5 □ Other (23d. Date of de Month	livery Day Yea
me ouriat-transit		C.	a consequence of						
cal ner	resulting in death)		a consequence of	•	/				9 manth
ian	shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each I	metastase		or oyill	g, coor as cardio			Interval Between Onset and Death
2 d	23a. Part1. Enter the disease, or o	ubach					e, P.A., Ow	ings, M	20736 Approximate
any injury once.	4 □ Donation 5 □ Other (Sp. 21: Signature of Funeral Service)		herropo			ss of Facility	,20,04 ATE	varior 14	, VA
any injury or other traumatic evonce. Once. To B	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp	,	20b. Place of 0	Disposition (A crematory of	lame of r other plac	е)		Location - City or	Town, State
rtraum	19a. Informant's Name/Relationshi						Rural Route Number, City eake Beach		
To Be			Jr.			Mildre			ster
				ome ma	ker	18. Mother's Na	ame (First, Middle, Maide	own home	e
Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or		Decedent's Us Give kind of t life. DO NOT	vork done	during most of we	orking 16b.	Kind of Business	s/Industry
d by Fi	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2√2 No	Specify:		Specif w hi	
Funeral Director	11. Marital Status	12. Was Decedent		13. Was Dec			Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
Dire	10e. Street and Number 3906 16th Str	reet		10f. 2	Zip Code 20732)		Citizen of What C	ountry?
ctor		:	Chesap		each				TY Yes 2
	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location			July 24,19	944 Nor	th Caroli
eral ctor			ge (In yrs. last birth	Month	er 1 Year s Days	If Under 24 Hr Hours Mir	8. Date of Birth (Month, Day, Yea	r) 9. Bii	rthplace (State or Fo
aminer	Calvert Memoria				-	r Location of Dea Prederic		c. County of Dea Calvert	ith
/sician ledical	Liliua LO		Beck	4h Ci	n. Tours o	r Logation of Dog	October		
							A d m makin		

Shirley 1 1-06892	But1	er	Pleas	e Type or Prir	nt in B	lack In	delible Inl	c Ensure Δ	II Conie	s Are I	egible	
dl			For 1 ≈ State Registrar			l / Depa		Health and I		ygiene (004	35979
	ysicia Medic		1. Decedent's Name (First, Middle, Shirley	Mae	But	tler			2. Date of D Month	Day	Year	3. Time of Death
	amine		4a. Facility Name (If not institution, Calvert Memoria					or Location of Death	Octob	4c. Co	4, 2004 ounty of Death lvert	
Fun Dire	eral ctor		5. Social Security Number 213-42-7954		e (In yrs. Ia	s <i>t birthday)</i> Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Date of B (Month, D Aug.	irth	9. Birth	place (State or Foreign intry) ryland
Maryland	fied at	Į.	Usual Residence of Decedent 10a. State 10b. County Maryland Cal	vert	10c. City,	Town or Lo		ke Beach				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the	nst be not	ral Director	10e. Street and Number 6630 01d Bay	side Road	1		10f. Zip Code	732		10g. Citize	n of What Cou	untry?
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show	Exactivativas be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 Xh If Yes, Give Year or Dates:			Was Decedent of f Yes, specify Cul I ☐ Yes 2 🎇 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)		Race - Ameri Black, White pecify: B1a	, etc.
Maryland 21215-0036 at 2 should be filed within 72 hours alt in and Mental Hygiene.	Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		(Give life. L		during most of work ad)	King	16b. Kind	of Business/Ir	ndustry
and 21 be filed wi nta! Hygien od other th	event, Inc	Be	12 17. Father's Name (First, Middle, La Calvert		Hawk		Homemal	18. Mother's Nam		, Maiden Su		
nore, Maryland 21215-0 tges 1 and 2 should be filed within 72 hc nt of Health and Menta! Hygiene. If item 27 is marked other than "natur	traumatic	<u>o</u>	19a. Informant's Name/Relationship Cim Joseph But			19b. Mailin	g Address (Stree	Mamie tand Number or Run ayside R	al Route Numb	er, City or To	ones	O Code) 20732
Baltimore, permit. Pages 1 ar Depertment of Hea mportant: If item	ry or otha	- [-	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Special Control of	☐Removal from State	20b. Plac cen Beth	ce of Dispos netery, crem	sition (Name of patory or other plate y Chr. ($\operatorname{Cem}.10/2$	Date 9/04	20c. Locat	tion - City or T	
Baltimore permit. Pages 1 Depertment of H Important: If ite	sny Inju		21. Signature of Funeral Service Lic		20	22.	Name and Addre	ess of Facility Se	well F	unera	а1 Ноп	,
Physic /Medi	cal		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each lin	SCLER	Do not ente	or the mode of dy	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Exami		vammer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	i nonecquer	res off:						
Box 68760, sath certificate be executed attending physician and	L	LYG	that initiated events resulting in death) Last	c. Due to (or as a	consequer	nce of):						
on of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate be in the this certificate has been signed by the attending physicial death of the control	ached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 🗌 Fetal de	eath 3 🗆 I	Ectopic pregnanc Other (specify)	у		23d.	Date of delive	ery Day Year
cords, P		֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other significant conditions LT MDH017 A	contributing to death bu	t not resultin	ng in the un	derlying cause giv	ven in Part I.				ne cause of death?
Vital Records, slcian: The law requires to certificate has been signed	page d				-				24a. Was autor perfo	rmed?	death?	psy findings available πpletion of cause of 2 No
of Vital F Physician: Th		2 :	25. Was case referred to medical examiner? 1 XYes 2 No	Hospital: 1 Inpatien	it 2 K ∫ER	/Outpatient	3□ ĐOA Oth	26. Place of Death	(Check only o	ne)	Other (Specific	·)
On C			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Bb. Time of Injury	28c. Injur Wor		28d. Describe I			

Division of To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

Medical Certification:

1 Natural
2 Accident

3 Suicide

29a. Certifier (Check only one)

4 - Homicide

29b. Signature and title of certifier

10

State

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA WS10, M111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day) 27 2004

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

October 25, 2004

Registrar

			1- For State of Maryla		artment of h			ene	35980
ı	Physici /Medi		Decedent's Name (First, Middle, Last) George Madison	1 Blanco			2. Date of Death Month	Day Year	3. Time of Death 7:30 AM
ě	Examir		4a. Fecility Name (If not institution, give street and number) Sacred Heart Hospi	tal		or Location of Death		4c. County of Dea	ath
	Funeral Director		217-66-7745 10 3 M 2□ F 51	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, October 14	Year) 9. Bii	nthplace (State or Foreign ountry) West Virginia
	faryland show	ō	Maryland Allegany	City, Town or Lo	ocation	Midland			10d. Inside City Limits 1 XYes 2 □ No
	with the N e or 28e-1	Direct	10e. Street and Number 14940 Paradise Street		10f. Zip Code	21542	10	g. Citizen of What C	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumetic event. If Ite Modical Ext. if Item is usable notified at once.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in In Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in In Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba	Hispanic Origin? (Spe an, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	erican Indian,
21215-0036	within 72 hour ne. then "neturel e Modical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 10	16a. Deced (Give life.	DO NOT use retire	pation during most of workir d) eatment Opera	-	6b. Kind of Business	
	should be filed on the marked other thanked other thanked other thanked other thanked other thanker th	To Be Co	17. Father's Name (First, Middle, Last) Manuel Blanco			18. Mother's Name	(First, Middle, Ma		- Water
Maryland	1 and 2 shou Health and M em 27 is man ither treumel		19a. Informant's Name/Relationship (Type, Print) Marsha Lynn Blanco-Wife	19b. Mailir		and Number or Rural 40 Paradise Stre			
Baltimore,	Pages 1 and ont of Heimout: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, cren	sition (Name of natory or other place erland Cremate	ce) N	ovember 06, 2004	0c. Location - City or Cumberlan	Town, State d, Maryland
Balti	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Licensee		. Name and Addre	,	ome 8 East N	Main St., Lonac	oning,Md. 21539
>.	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse			1			Approximate Interval Between Onset and Death
,8760,	ate be executed hysician and the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consect of the condition of the consect of the condition of the condi		homic	Cardoc	myopa	: My	64 Purs
.O. Box 6	that the death certific ed by the attending p detached for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fett 4 □ Pregnant at time of 6 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Dther significant conditions contributing to death but not reconditions.	sulting in the ur	nderlying cause grv	en in Part I.	23e. Did toba		the cause of death?
Vital Record		Completed	Uphticular at Chronic Chs ha	ur hy	Pulmone.			prior to death?	topsy findings available completion of cause of
	Physicie this cert al directe	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	PR/Outpatient	t 3□ DOA Othe	4 Nursing Hom	e 5 🗆 Residend	ce 6 □Other (Spec	city)
Division of	To the Hospital or Attending Physicien: within 24 hours after deals and the Funds of the Funder Director. After this certific completely filled in by the funeral director,	Certification;	1 ♣Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	28b. Time of Injury		Yes 2 □No	3d. Describe how		
<u>></u>	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the		4 Homicide determined 200. Place of Injury - At in building, etc. (Special	ity)			City or Town, S	·	
	To the Hospite within 24 hours To the Funerel completely filled	le dical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known one) 1 Medical Examiner: On the basis of examinar and manner stated.	owledge, death ation and/or inv	estigation, in my or	pinion, death occurred	d at the time, date	and place, and due	to the cause(s)
	Towith	Σ	29b. Signature and title of certifier	1/1	29c. License) 357	35 290	Date signed (Month	n, Day, Year)
1	nds		30. Name and address of person who completed cause of death (Iter	m 23a) (Type, F		Chan D-	Camb	erland w	10 21502
	Sta Registr	-	31. Date filed (Month, Day, Year) 38 Registrat's Signal (NOV 0 5 2004)	ature g	Sparks				

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or itams 23a or 28a-f show any injury or other traumatic avant. The Medical Examinational Desired Hybrid at ODE.

Physician /Medical

Baltimore, Maryland 21215-0036

I	1- For Unpend Ite	m 23State of M		delible Ink. Ens artment of Health ertificate of Deatl	and Mental Hyg	jie De () () ()	35982	
ian	Decedent's Name (First, Middle Pamela	в, Last) K.	Brown		2. Date of Dea Month	Day Year	3. Time of Death	
ical ner	4a. Facility Name (If not institution MEMORIAL HOSP			4b. City, Town, or Location CUMBERLAND	of Death	5, 2004 4c. County of Dea	th	
	5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year If Under	or 24 Hrs. 8. Date of Birth	ALLEGAN 9. Bir	thplace (State or Fore	
	214-84-1883 Usual Residence of Decedent	1 M 2 D F	46 Yrs.	Months Days Hours	Jun 12,	1958	MD	
or	10a. State 10b. County MD Alleg	gany	10c. City, Town or Lo	erland			10d. Inside City Lin 1√ Yes 2 □	
Director	10e. Street and Number			10f. Zip Code	1	0g. Citizen of What Co		
	606 Eim Street			2150		USA		
Funeral	11. Marital Status 11 Never Married 2 Marr	12. Was Decedent Armed Forces	?	Was Decedent of Hispanic Of f Yes, specify Cuban, Mexica	rigin? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - Ame Black, Whit		
by	3 Widowed 4 Divorced	If Yes Give A		1 ☐ Yes 2 No Specify	<i>/:</i>	Specify: wh	ite	
ietec	15. Deceden (Specify only highes	t's Education st grade completed)	(Give	dent's Usual Occupation kind of work done during mo DO NOT use retired)	est of working	16b. Kind of Business	/Industry	
Completed	Elementary/Secondary (0-12)	College (1-4or	disable		r	n/a		
o Be C	17. Father's Name (First, Middle, Robert J. Brown	*	, , , , ,		ner's Name <i>(First, Middle, I</i> rgaret Jo Ann		own	
-	19a. Informant's Name/Relations Kimberly Lewis	hip (Type, Print)	r 19b. Mailir	ng Address (Street and Numb Grand Avenue	ber or Rural Route Number	, City or Town, State, 2		
	20a. Method of Disposition		20b. Place of Dispo			20c. Location - City or		
	1 🔀 Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S		Sunset Mem		11/9/2004	Cumberlan	d MD	
	21. Signature of Funeral Service	Licensee	22	. Name and Address of Faci Scarpelli Fune	ral Home, PA			
	23a. Part 1. Enter the disease, or	complications that cause	M	108 Virginia A	venue: Cumberla	and, MD 2150		
	Immediate Cause (Final	only one cause on each I	ine.		s cardiac or respiratory arre	351,	Approximate Interval Between Onset and Death	
	disease or condition resulting in death)	а.	Intoxicat: a consequence of);	LOII				
L	Sequentially list conditions,	b						
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
Exar	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
		d						
/Med	IF FEMALE:	22a If yes outcome	of programmy		-			
Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 【 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year	
by	Part II. Other significant condition				_	pacco use contribute to	5. 1/	
Completed	nypertensive At	Her OSCIETOLI	ic Cardiova.	ovascular Disease 1 Yes 2 No 3 Probably 4 Unknot 24a. Was an 24b. Were autopsy findings availa				
					autops perform 1 💢 Yes 2	y prior to death?	completion of cause of	
Be	25. Was case referred to medical examiner? XXYes 2 No	Hospital:	ent 2 ER/Outpatien	Other	e of Death (Check only one ursing Home 5 \sum Reside		si6.)	
0	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	ry 28b. Time of	28c. Injury at Work?	28d. Describe ho		···• /	
P.	- I LIVALUIGI DI FENGIN			M 1 ☐ Yes 2 X	No Unknown			
P.	2 Accident Investig	othe 11-5-200		ne, farm, street, factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State) 606 Elm Street				
0		not be 28e. Place of In		eet, factory, office	28f. Location (Str City or Town Cumber1a	eet and Number of Ru . State) 606 ELI	a Street	

Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filted in by the funderal director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> LING 31. Date filed (Month, Day, Year) State NOV 1 5 2004 Registrar

29b. Signature and title of certifier

ai

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

NOV. 6, 2004

miD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

State Registrar

31. Date filed (Month, Day, Year) OCT 2 8 2004

CHROL

Aw ma 2. Registrar's Signature

cause of death (Item 23a) (Type, Print)

O.C.M.E.

October 22, 2004

111 Penn Street, Baltimore, Maryland 21201

			For Stata Registrar	State of	Marylan		artment rtificate			ind M	ental Hyg	iene	004	35	984
	Physici		1. Decedent's Name (First, Middle, La. Juan BONANO	st)							2. Date of Deat Month Novembe	Day	Year 2004	3. Time	of Death
	/Medic Examir		4a. Facility Name (If not institution, given Beverly Health (per)				Location of	f Death		_	ounty of Deat	h	o pomo
	Funeral Director		117-24-7370	ex DXM 2□F	. Age (In yrs. 75	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Dec. 9,			hplace (State untry) erto R	e or Foreign
	ter death with the Maryland Items 23s or 28s-f show included by confilled at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Washir	ngton	10c. Cit	y, Town or Lo	cation erstov	√n						10d. Inside	City Limits
	h with th	al Director	10e. Street and Number 750 Dual Highway	7			10f. Zip	Code	2174	0	10	g. Citize	n of What Co		
036	72 hours after death with the Maryland netural', or Hems 23a or 28a-f show disal Examinar must be indiffed at	by Funeral	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Forc 1 12 Yes 2 If Yes, Give Year or Dat	es? :□No		Was Decede f Yes, speci				cify Yes or No- lican, etc.)		Race - Ame Black, White Decify:	e, etc.	Rican
Maryland 21215-0036	within ene. than	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		lor 5+)	(Give	dent's Usual kind of work DO NOT use COOk	k doné d e retired)	urina most	of workin	g		of Business/		
land	uld be filed fental Hygi rked other tic event, t	To Be C	17. Father's Name (First, Middle, Last) Genaro Bonano								(First, Middle, M		ımame)		
	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 Is marked othe or other traumatic event,		19a. Informant's Name/Relationship (Valerie Bonano -			10					Route Number, Hagerst				1740
Baltimore,	Pages 1 and ment of He ant: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		ate C	Place of Dispo emetery, crer gerstov	natory or oti	her place	. 1	Da 11/2			tion - City or 1		yland
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	Mu	muc	A	. Name and			LI	NNICH H Hagers				
5	Physician /Medical Examiner		23a. Part1. Enter the disease, or confusions, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	as a consequence	offici uence of):		iov	iscul	5	respiratory arre			Approxim Interval B Onset and	d Death
8760,	icate be executed physician and sthe burial-transit	dical Examiner	S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequal	uence ot):		710 7	resc					rai	73
P.O. Box 6	he death certif the attending thed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal nt at time of di	Ideath 3□	Ectopic pre Other (spe	gnancy cify)				230	d. Date of delin	very Day	Year
	ires tha signed d be de	by	Part If. Other significant conditions of	ontributing to dea	th but not res	ulting in the u	nderlying ca	use give	n in Part I.			acco use	contribute to		death?
Division of Vital Records,		Completed								_	24a. Was and autopsy perform		24b. Were aut prior to codeath?	opsy finding ompletion of 2 No	s available cause of
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical — examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ Inc	patient 2	ER/Outpatien	t 3□ DOA	Other			(Check only one e 5 ☐ Resider		Other (Spec	i6a)	
ion of	ding h. After fune	ertification; T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of (Month,		28b. Time of Injury		c. Injury Work		28	3d. Describe how			(y)	
Divis	tal or Atten rs after deatl al Director: ed in by the	Certific	3 Suicide 6 Could not be determined	288. Place 0	f Injury - At ho , etc. <i>(Specif</i>)	ome, farm, stri	eet, factory,	office		28	Bf. Location (Stre City or Town,		lumber or Rui	a <i>l R</i> oute Nu	mber,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exem	ysician: To the b niner: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred a restigation, i	t the time in my opi	e, date and inion, death	place, ar occurred	nd due to the car d at the time, da	use(s) an le and pla	d manner as ace, and due	stated. to the cause	(s)
-	within 2	Σ	29b. Signature and title of certifier Mayou #\$	naj			,	License D 28	21.				igned (Month,	Day, Year)	
	N'S		30. Name and address of person who MANZAR	completed cause	of death (Item	23a) (Type,	Print) Street	1-19	lager	stau	un teg	りつ	740		
	Sta Registr		31. Date filed (Month TVY 07) 3 2	004 32. 750	gistrar's Signa	ture G. A.	rester		U						

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death

35985

		_				Certificate U	Dealli		Reg. No.		
	Physici		1. Decedent's Name (First, Middle, Last) Bennett Dulahbohn	BARBER				2. Date of De Month Octobe	Day	Year	3. Time of Death
1	/Medic		4a. Facility Name (If not institution, give s				4b. City Town, or	Location of Death			15:07
1	Examir	ıer							,		
	-	_	Carroll County Ge 5. Social Security Number 6. Sex		spicai. e (In yrs. last birti	hday) If Undar 1 Yea		inster 8. Date of Bir	Carr		lana (Chaha an Fauria)
	Funeral Director			M 2□ F		rs. Months Day		. (Month, Da	y, Year)		lace (State or Foreign
		3 1	Usual Residence of Decedent		10			April 2	1956	mary	yland
	/land		10a. State 10b. County		10c. City, Town	or Location				10	0d. Inside City Limits
	Maria San	ţō	Maryland Washin	gton		Hagerstow	7 n				1 ☐ Yes 2 🖾 No
	128 a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Coun	itry?
	3a o	Ē	11342 Rockhill Ro	ad		217	40		USA		
	deatl	Funerai	11. Marital Status 1	2. Was Decedent	Ever in U,S.	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Specify Yes or No		- America	an Indian,
0	ar te		1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☑ Yes 2 ☐ I	No			rto Rican, etc.)	Black	k, White, e	etc.
Š	d within 72 hours efter death with the Maryland jiene. Ithan "natural", or items 23a or 28e-f show the Madical Exandres must be notified at	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1973-77	1 ☐ Yes 2 🖾 N	o Specify:		Specify:	wh	nite
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. l	Decedent's Usual Occ	upation	ricina	16b. Kind of Bu	siness/Ind	fustry
2	Ban B	ple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Give kind of work don life. DO NOT use retii	red)	nking			
7	72 E L 27	5	12	0		machine op	erator		ic	e cre	eam mfg.
nd	be filed Ital Hyg Id other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame	э)	
yla		၉	William H. Barber				Rebeco	ca Elliot	t		
lar	d 2 should th end Mer 7 is merke traumetic		19a. Informant's Name/Relationship (Typ	e, Print)	19b.	Mailing Address (Stree	et and Number or R	ural Route Numbe	r, City or Town, S	State, Zip	Code)
≥,			Lisa M. Barber - w	ife	1	1342 Rockh	ill Road,	Hagerst	own, Ma	ry1ar	nd 21740
Baltimore, Maryland 21215-0020	es 1 en of Heali litem 2 r other		20a. Method of Disposition	manual from Chata	20b. Place of cemetery	Disposition (Name of , crematory or other pi	lace)	Date	20c. Location - 0	City or Tov	wn, State
Ĕ	permit. Pages 1 Department of F Important: if ite any injury or ot once.		1 ☐ Burial 2 XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Hagers	town Crema	atory	11/2/04	Hagers	town	, Maryland
alti	permit. Departn Importa any inju	H	21. Signature of Funeral Service License	ə	. 0	22. Name and Add			I FUNERA		-
œ	8 9 E 8 8) SOUTH	M		415 E. Wi	llson Blvd				-
			23a. Part1. Enter the disease, or complic	ations that caused	the death. Do no	1				ŧ	Approximate
Winds.	Physician		shock, or heart failure. List only one	cause on each lir	10.	^			,		Interval Between Onset and Death
1	/Medical		Immediate Cause (Final	H	5/1	11)				1	11 14 45
	Examiner		disease or condition resulting in death) a.		Due to (or as a co	onsequence of):					Vinate
		ner			200 10 (0) 03 0 01	onsequence on.					
	ath certificete be executed ttending physician end or use as the buriel-transit	Examiner	Sequentially list conditions.	- 8	Dos to (or as a oc	, isequence of,				-240	
oʻ	an el		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.								
376	ysici he bu	ca	that initiated events resulting in death) Last		Due to (or as a co	nsequence of):				-	
3ox 68760,	ng ph as t	an/Medical	Tooding in doding East							1	
õ	th ce rendii	an/	d.								
	de de	Physici	Part II. Other algnificant conditions contr	ibuting to death bu	it not resulting in	the underlying cause g	jiven in Part I.	23b. Did t	obacco use cont	ribute to	the cause of death?
<u>О</u>	at the	Æ						101	ea 2□No	3 ☐ Prob	ably 4 Z Unknown
Ś	esth igner bood	5									
or o	requires that the	3						24a. Was a		24b. Wer avai	re autopsy findings ilable prior to
ပ္	law r las be					P8 6 1/10 -					pletion of cause leath?
<u>~</u>	The ete h	Completed						1 □ Y	es 2 No	1 🗆	Yes 2□ No
Division of Vital Records,	ian: prific ctor,	Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only or	16)		
<u>~</u>	Physician: this certific ral director,	ᅙ	1 ✓ Yes 2 □ No	spital: 1 🗆 Inpatie	nt 2 RER/Outp	eatient 3 DOA	ther: 4 🗆 Nursing F	lome 5□ Resid	ence 6 Other	(Specify))
ם	Ter there		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tir Year) Inj	ne of 28c. Injury Wo	ury at ork?	28d. Describe h	ow injury occurre	ď	
<u>0</u>	Attanding ir death. ector: Aflei by the fune	äţi	2 ☐ Accident investigation				∃Yes 2□No				
<u>≝</u>	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farn . (Specify)	n, street, factory, office	9	28f. Location (S City or Tow	treet and Number n. State)	r or Rural	Route Number,
Ω	To the Hospital or Attanding Physician: The law within 24 hours effer death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2	S									
	Hosp 4 hou une ely fii	edicai	29a. Certifier (Check only one) 1☐ Certifying Physic 2 ✓ Medical Examine	cian: To the best o	f my knowledge, o	death occurred at the tor investigation, in my	time, date and place	, and due to the c	ause(s) and man	ner as sta	ited.
	the the mplet	Med	Units)	and manner sta	ted.						
		-	29b. Signature and title of certifier			29c. Licen	ise number	2	9d. Date signed	(Month, D	ay, Year)
	LX		PVYY			P00°	31924	NC NC	vembe	11	2004
	xx.5x1		30. Name and address of person who com			ype, Print)		•			
V	<i>/</i>		Dr. Herbert Hender	son, 297		ster Rd.,	Mancheste	er, Md. 2	1102		
	Stat Registra	te ar	31. Date filed (Month Cay, Year) 200	32. Hegistra	r's Signature	A					
DH	H 16 Rev 6/95			MARKET	J. J.	spoured					
PITIN	10 1404 0480	•									

State of Maryland / Department of Health and Mental Hygiene

35986

				Certi	ficate of	Death		Reg. No.	OT	0000
	Physician	Decedent's Name (First, Middle, Last)	2022122				2. Date of De		Vear	3. Time of Death
	/Medical	Virginia Ma					Octobe		0'0'4	8:58 PM
	Examiner	4a Facility Name (If not institution, give street and Julia Manor	'number)			4b. City, Town, o Hagerst	r Location of Death COWN		of Death ingto	n
	Funeral	5. Social Security Number 6. Sex 213 -12 7358 1□ M 2\overline{12}	7. Age (In yrs. le	A	f Under 1 Year lonths Days	If Under 24 Hr Hours Mir	n. (Month, Da	v. Year)	9. Birthple	ace (State or Foreign
	Director	Usual Residence of Decedent	F 85	Yrs. "			March	17, 191	9 Pen	nsylvania
	Mend Mend	10a. State 10b. County	10c. City,	Town or Locat	ion				10	d. Inside City Limits
	Mar Mar	Maryland Washington	Ha	gerstow	n					1X Yes 2 □ No
	vith the Mar or 28a-f s be nothined	10e. Street and Number			10f. Zip Code			10g. Citizen of		ry?
	ath w	11 West Baltimore St	reet		2	1740		U.S.A	. •	
	ofter death vitems 23s	11. Marital Status 12. Was D	ecedent Ever in U,S Forces?	5. 13. Wa	s Decedent of H es, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Rad Bla	ce - America ck, White, e	
Maryland 21215-0020	led within 72 hours efter death with the Maryland lygiene. Net than "natural", or items 23s or 28s-f show it, the Medical Exeminer must be notitled at Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ You If Yes, 3 ☒ Widowed 4 ☐ Divorced Year of	es 2 No Give or Dates:		Yes 2⊠ No	Specify:		Specif	/: w1	hite
15	n 72 i	15. Decedent's Education (Specify only highest grade complete	ed)	16a. Deceden	t's Usual Occup d of work done o	ation du <i>ring most</i> of wo f)	orking	16b. Kind of B	usiness/Indu	ıstry
212	be filed within tel Hygiene. d other than "r event, the Med	Elementary/Secondary (0-12) Colleg	0 (1-4or 5+)	homem		'/		her o	wn ho	me
פַ	生工 草 第 40	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Surnar	18)	
/lar	should be and Mentel or marked o urmatic ev	Fred Daniel Po	per				Edna I	dell Lo	hman	
lan	end s mu	19a. Informant's Name/Relationship (Type, Print)					Rurel Route Numbe			
6,5	1 end 2 Health em 27 i	Robert D. Boward, Jr.					Hagerst			
Baltimore,	S to L	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal fro	ALL STATE		on (Name of ory or other place		Nov. 2,	20c. Location -	•	
Ħ	it. Pag intment intent: I injury o	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Res		Cemete	-	2004			Maryland
Ba	permit. I Departm Importar any Injui	21. Signature of Political Service Liberises	0-				Minnich			
		23a. Part 1. Enter the disease, or complications the	at caused the death							yland 2174
1	Physician	shock, or heart failure. List only one cause of	n each line.	DO HOL GIRLOLD	te mode of dynn	g, such as cardie	ic or respiratory ar	1651,	į	Approximate Interval Between Onset and Death
	/Medical	Immediate Cause (Final disease or condition	ROTPIN	TIVE	TAI	NOICE			!	1110
N.	Examiner	resulting in death)		as a consequer		MINICO				7 10
	executed in end iel-transit	b HY	PERENSIV	E CAK	COLOVASO	FULAR	DISEA	(E		2.CY
6	wacut end el-tran	Sequentially list conditions, if any, leading to immediate		as a consequer						
68760,	sician buria	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
89	certificate be executed rding physician end use es the buriel-transit	resulting in death) Last	Due to (or a	as a consequen	ce of):					
XO		d				-				
Ö.	at the death d by the etter leteched for u	Part II. Other significant conditions contributing to	death but not result	ing in the unde	lying cause give	en in Part I.	23b. Did to	obacco use co	ntribute to t	the cause of death?
P. O.	d by t						101	es 2□ No	3 ☐ Proba	ıbly 4 ☐ Unknown
ds,	signe d be d								045 14/	
Division of Vital Records,	The law requires that the death sete has been signed by the etter, page 2 should be deteched for Completed by Physicial						24a. Was a perfor	in autopsy med?	avail	e autopsy findings lable prior to pletion of cause eath?
E	The iante te has bage 2						104	es 25(No		Yes 2□ No
<u>i</u>	clan: 'entifice ector, pactor, p	25. Was case referred to medical examiner?				26. Place of De	ath (Check only or			
<u>></u>	Physician: rthis certific aral director, r: To Be (1 Yes 25 No Hospital: 1 I	☐ Inpatient 2☐ El	R/Outpatient	3□ DOA Othe	er: 4 Mursing I	Home 5□Resid	ence 6 DOth	er (Specify)	
L C	Ing P on:	1 SaNatural 5 □ Pending (M	te of Injury onth, Dey Year)	8b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occurr	ed	
S	Attending or death. •ctor: After by the fune	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No	006 1 100			
<u>≥</u>	tal or Attending P rs efter death. al Director: After t led in by the funera Certification:	4 Homicide determined but	ice of Injury - At hom ilding, etc. (Specify)	ie, iaim, street,	тастогу, оптов		28f. Location (S City or Tow	n, State)	ar or Hurai i	Houte Number,
	To the Hospital or Attending Physician: The law requires that the death within 24 hours effer death. within 24 hours effer death. completely filled in by the funeral director, page 2 should be deteched for moletely filled in by the funeral director, page 2 should be deteched for Medical Certification: To Be Completed by Physicia	29a. Certifier (Check only one) 12 Certifying Physician: To to the and m.	he best of my knowle basis of examinatio anner stated.	edge, death occ n and/or invest	curred at the tim gation, in my op	e, date and place pinion, death occu	e, and due to the c urred at the time, d	ause(s) and ma ate and place, a	nner as stat ind due to tl	ed. he cause(s)
	Within To the comp	29b. Signature and title of certifier			29c. License	number		9d. Date signed		ay, Year)
•		396			P62	323		18/29/	14	
	11/10	30. Name and address of person who completed ca	use of death (Item 2	3a) (Type, Prin	t)				1	
-	<u> </u>	Or Waseem 11	2600	al Co	470	Hag	md 2	1746		
44°	State	31. Date filed (Month, Day, Year) 32. NOV 0 3 2004	Registrar's Signatur			1		_		
DHA	Registrar	0 0 2004	Molen D	4. Spe	Kel					

State of Maryland / Department of Health and Mental Hygiene 2004 35987 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 2004 7:40 p M **GEORGE** BRODEUR 26, PHILLOIS /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harborside Health Care, Larkin Chase Bowie

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Month, Day, Feb. 17, Prince George's 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1**∑**M 2□F 82 029-18-0772 Massachusetts Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai", or items 23a or 28a-f show Examinar must be notified at 1 X Yes 2 ☐ No Greenbelt Maryland | Prince George's Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22 Ridge Road, Apt. 219 20770 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1942 -14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 1945 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic sysnt, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Pressman 12 Cornelius 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Ernest Brodeur Emma Mass' 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Ridge Road, Apt. 219, Greenbelt, Maryland 20770 Rita C. Brodeur - Spouse 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or otl ang.e. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/28/2004 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Linear 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ause on each line. Approximate Interval Between Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner eucea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jacks of July that initiated events Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physician a Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No 9 Unknown signed t Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? Yes 2 No has page 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature of title of certifier 29d. Date signed (Month, Day, Year) 11/8 D57028 October 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra, MD 600 Ridgely Avenue, Ste. 231, Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 8 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 004 35988 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 24,2004 **Physician** BROOKS 5:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7317 Moores Road Prince Georges Brandywine ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year)

Months Days Hours Min (Month Day, Year) 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□ F 81 Director 218-20-1014 Usual Residence of Decedent death with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. tnside City Limits 28e-f ehow 27 le marked other than "natural", or Items 23e or 28e-f ehov traumatic evant, the Madical Examiner must be notified at XXYes 2 No Director Maryland Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7317 Moores Road 20613 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Iten any injury or other traumatic evant, the Medical Examinar once. Black, White, etc. 1 Never Married Married ☐Yes 2X No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Washington Gas Co Equipment Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William 0. **Brooks** Jannie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Brooks/ Wife 7317 Moores Rd Brandywine, Maryland 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 Donation 5 Other (Specify) Asbury UMC Cemetery 10/30/04 Brandywine, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Outer Odessa MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE **Physician** HEART disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy ned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ALZHIEMERS BISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed this certificate has 2.2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred e Hospitel or Attanding Pl 24 hours after death. a Funaral Diractor; After the tnjury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funeral D Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) w D0013073 10/26/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8926 Woodyard Rd Clinton, Maryland 20735 Dr. Harvey Katzen 31. Date filed (Month, Day, Year) gistrar's Signature State Registra OCT 2 7 2004

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	Funeral			6. Sex 7. Age (In yr.				8. Date of Birth	Wicomico	
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	aryla	_	10a. State 10b. County		City, Town or					10d. Inside City Limits
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	or 2	Olre	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What C	ountry?
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	er de Items	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	erican Indian,
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211	that the de led by the a detached f	hys	9 🗆 Unknown	9 Unknown						
2 ,	The law requires that the death certified has been signed by the attending age 2 should be detached for use a	by P	Part II. Other significant conditions	s contributing to death but not re-	sulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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		-	30. Name and address of person wh	o completed cause of death (Iter	n 23a) (Type	, Print)	-1-1		1 401	
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State of Maryland / Department of Health and Mental Hygiene 00 L 35991 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Cawood, Sr. 12:12 PM^M Ralph 27. Donnie October 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset Deal Island 9956 India Lane If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 M 2 F 11-26-1939 Director Tennessee 549-54-9456 64 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-1 show eny Injury or other traumatic event, the Medical Exercises. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 No Deal Island Somerset Direct 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code USA 9956 India Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: Specify. δ 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Marine Construction Boat Builder 10 none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nina Ware Ernest Cawood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9956 India Lane, Deal Island, MD 21821 Ina Mae Cawood/Wife 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2004 Salisbury, Maryland 4 □Donation 5 □ Other (Specify) Salisbury Crematory 22. Name and Address of Facility
Hinman Funeral Home 21. Signature of Funeral Service Licensee M00295 11673 Somerset Ave., Princess Anne, MD 21853 23a. Po 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final dispase or condition resulting in death) netas Canca **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown s been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has certificate 1 Yes 2 No To the Hospital or Attending Physicien: ours after death.

eral Director: After this certification by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier BC1616777 on 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL 57. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Registrar

State

31. Date filed (Month, Day, Year) 0 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Penn Street, Baltimore, Maryland 21201

			For State Registrar	State of M	laryla r	nd / Depa <i>Ce</i>	artmen rtificate	t of He e <i>of D</i>	ealth ar Teath	nd Me	ental Hyg	iene 2	2004	35993
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1 10	Physic /Medi		Willie Mae	Choice						(Month October	25,2	2004	14:51p ^M
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4	Funeral Director		577-52 - 2599	1 □ M 2 1 F	.ge (<i>in yr</i> s. 71	last birthday) Yrs.	Months Months	Days	If Under 24 Hours	Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Cour	place (State or Foreign ntry)
Sign.	D		Usual Residence of Decedent							Į.	Aug. 24,	1933	Wash	ington, D.
	nrylan show	_	10a. State 10b. County 10c. City, Town or Location Cheverly								1	0d. Inside City Limits		
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36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other traumatic event, Ira Medical Evanting must be notified at once.	y Funeral Director	1 Never Married 2 Married	Armed Forces 1 Yes 2 If Yes, Give	?	1	f Yes, spec	_	Mexican, F Specify:	Puerto R	ify Yes or No- ican, etc.)		Black, White,	etc.
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ylaı	Menta Menta arked	To	Willie Barley						Louis	se M	ills			
Maryland 21215-0036	2 shd and Is m		19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street and	Number o	or Rural	Route Number,	City or To	own, State, Zip	
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	of or Attend after death Director: / d in by the t	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At hor c. <i>(Specify</i> ,	me, farm, stre	et, factory, o	office		28f	Location (Stre City or Town,	et and Nu State)	umber or Rural	Route Number,
	G 7 8 =	edical C	29a. Certifier 1 Certifying Ph	ysicien: To the best	of my knov	vledge, death	occurred at	the time, o	date and pla	ace, and	due to the cau	se(s) and	manner as star	ted.
	To the Hos	Med	one) 29b. Signature and title of certifier	and manner sta	ated.	- Tunior in IVE				-curred				
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	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.		If Unde	r 1 Year	If Under 24	Hrs. 8	. Date of Birt (Month, Day		9. Bin	hplace (State	or Foreign
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	ams	ıner	11. Marital Status	1:	2. Was Dece Armed Fo	dent Ever in U	.S. 13.	Was Dece	dent of H	lispanic Origin an, Mexican, F	n? (Speci Puerto Ric	fy Yes or No- can, etc.)		14. Race - Ame Black, Whit		
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nd	be filed within 72 hours after death with the Marylar hat Hygliene, od other then "netural", or items 23e or 28e-f show other then "netural", or event, the Medical Examiner mail be notified at	Be	17. Father's Name (First, Middle									First, Middle,		Sumame)		
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ē,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		20a. Method of Disposition			20b. F	Place of Dispo	sition (Na	me of		Dat	А		cation - City or		02_
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P.0	Pa de de		Part II. Other significant condit	ions cont	ributing to de	eath but not res	ulting in the u	nderlying	cause giv	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of	death?
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	4		30. Name and address of perso	n who con	12	c - cop	DAOD	Print)								
			Ruth Kevess-					gia <i>P</i>	venu	e, #40	0, S	ilver	Spri	ng, MD	20910	
*	Sta Registr		31. Date filed (Month, Day, Yea			egistrar's Signa	ature &	Spo	uls	/						

State of Maryland / Department of Health and Mental Hygiene 2004 35995 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCT. **Physician** 24, GERTRUDE L. CROSS 11:55 PM 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Rehab Center MONTGOMERY Rockville 8. Date of Birth (Month, Day, Year) Apr. 24, 1927 5. Social Security Number 6. Şex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) **Funeral** Days Hours Min. Months 1 ☐ M 2 🔀 F 77 Maryland 218-30-4944 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Ie marked other than "natural", or items 23e or 28e-1 ehov eny injury or other traumatic event, If a Medical Examinar must be notified at MD Yes 2 No Director Montgomery Poolesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 17412 Hoskinson Road 20837 U.S.A. Completed by Funeral 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes ZONo ¥ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Engineer 6th Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be James R. Cross Florence R. Cooper ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilbert Cross (Son) 17412 Hoskinson Rd., Poolesville, MD 20837 20b. Place of Disposition (Name of complete, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State infury or 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Ştape Souls Cemetery 10/29-04 * 4 ☐ Donation 5 ☐ Other (Specify) Germantown, MD 21. Signature of Funeral Service Liceou 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1☐ Yes 2☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 7 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Maturel М 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ÷ 29b. Signature and title of certifie 29d. Date signed (Month, Dey, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 and AVC, Suitc # Yoy B Shanyar Dayar. MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 28

2004

32. Registrar's Signature

Spring,

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 35996 Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death **Physician BRENDA** LEE CRATTY OCTOBER 23 2004 19:22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CECIL SUNBRIDGE CARE AND REHABILITATION ELKTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Adaptive Dave Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 219-58-0380 55 Yrs. JULY 3, MARYLAND Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No MD CECIL **ELKTON** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 29 **AUGUSTA** DRIVE UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: ⋧ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wire Department of Health and Mental Hygien Important: If itam 27 is marked othar thu any injury or other traumatic event, Itam once. COSMETICS HATRDRESSER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LEILIA EUGENE N. COULBOURNE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 ARCADIA TRACE ROAD PEACHBOTTOM, PA17563 DEBORAH MCELROY DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State 10/26/2004 `4 □ Donation 5 □ Other (Specify) MAYERDALE CREMATORY NEWARK, DE 22. Name and Address of Facility SPICER-MULLIKIN FUNERAL HOMES INC 1000 N. DUPONT HWY. NEW CASTLE, DE 19720 con 22a. Part1. Enter the disease, or senshock, or heart failure. List only Approximate Interval Between Onset and Death Do not ent at the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Priysician CIMUS /Medical Due to for as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐+NO 9 Unknown 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2ELNO 1 🗌 Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 THO 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

Division of Vital Records, P.O. Box 68760,

signed by the attending physicien and I be detached for use as the burial-transit certificate be executed been si ispital or Attanding Physician: Thours after death.
Ingrel Diractor: After this certificate filled in by the funeral director, pt To the Hospital o within 24 hours af To the Funarel Di

r than "natural", or Itams 23a or 28a-f shov The Medical Examiner must be notified at

within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier

29b. Signature and title of certifier

(Month. **2 9** Dav. Year)



Name and address of person who completed cause of death (Item 23) (Type, Print)

10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1004 35997 Amend PI,25,27,28a-f, perME, g866, 4/25/07TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** /Medical Helen Moretta Chaney 4b. City, Town, or Localion of Death 4c. County of Deeth 11:00AM 4e Facility Neme (If not institution, give street end number) Examiner Cumberland 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Allegany

9. Birthplace (State or Foreign Country) Cumberland Villa Nursing Center
5. Social Security Number 6. Sex 7. Ag If Under 1 Year 7. Age (In yrs. lest birthdey) **Funeral** Days Months 1□ M 20 F Director 214-62-4041 Usuel Residence of Decedent 19-Jun-1952 Maryland Peges 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Health end Mental Hygiene. Int: if Item 27 is marked other than "natural", or Items 23s or 28s-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Allegany Frostburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 216 Shaw Street Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give (Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify Specify: 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teacher board of education 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Robert Chaney Louise Kelly

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11503 Dobbin Dr., N.W. Linda Ralev Frostburg Maryland 21532-20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Mount Zion Cemetery 05-Nov-2004 Frostburg 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) syndrome Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for usa as the burial-transit or Attanding Physician: The law requiras that tha death certificata be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2□ No 3 □ Probably 4 Drunknown ģ 24b. Were autopsy findings available prior to Be Completed 24a. Wes an autopsy performed? completion of cause of death? ZZNo 1 ☐ Yes 2 😿 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 Yes - 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this Aftar this funaral c 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Watural 2 Accident 1 ☐ Yes 2 No after death. Director: And in by the f unk unk subject in motor vehicle accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral Di completaly filled in unk unk the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Yeer) Worsock Sh 00055325 NOV 03, 2004

Registrar

nes

State

Frostburg MD 21532

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WONSOCK SIIN

NOV 0 4 2004

31. Date filed (Month, Day, Year)

48 Tarn

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 35998 = State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** MARGARET THERESA CALCAGNO 27 10 04 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, Year) 5/5/1944 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 60 NY Director 099-34-3885 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other treumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Ocean City Worcester MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 21842 **USA** 9705 Village Lane or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married White | S ~ cit of | | Maryland 21215-0036 1 Yes 2 No tf Yes, Give Year or Dates: Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **President** Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental and Mental Agnes Toner John Whalen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1176 Patricia Ave West Islip, NY nt of Health a Patrick Calcagno Baltimore, 20b. Place of Disposition (Name of cametery, crematory of oad? Kace) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 11/1/04 injury or permit. Page Department of Importent: If any injury or once. Kew Gardens, NY Maple Grove Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** umos 3 dec. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical the attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2 No P.0. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. should be 3 Probably 4 ∰Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 2 No director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 ∃Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 400 1 Tes 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After ! 5 Pending investigation Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat e Funerel Director: in by the 3 Suicide 6 ☐ Could not be 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the I 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 14/SIC11. 30. Name and address of person who completed ause of 'eath ('tem 23a) (Type, Print) Robert De 1600 31. Date filed (Month, Day, Year) 0CT 2 8 2004 State (Darke Registrar

				partment of Health and M ertificate of Death	_	ne N2004 ;	35999			
I	Physici	20	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death			
	Physici /Medic		Olivia Cholatian		00.00	24 2004	1601 M			
	Examin	er	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital	4b. City, Town, or Location of Death 01ney		4c. County of Death Montgome:	rv			
	Funeral Director		5. Social Security Number 219.82.6439 6. Sex 1 □ M 2 ☑ F 60 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 6, 19	9. Birthplac	ce (State or Foreign			
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		100	I. Inside City Limits			
	Maryla f sho	tor	Maryland Montgomery Olney				1⊠Yes 2□No			
	h the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country	1?			
	23a c	raiD	4113 Morningwood Drive	20832		U.S.A.				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deprintment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-f show any injury open traumatic event, it a Medical Execution cast be notified at once.	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race · American Black, White, etc	c.			
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ž	and 2 alth a 27 is		Siran Levonian/Sister 220	5 Parallel Lane, Si						
Baltimore,	es 1.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	rematory or other place)	ate 20c	Location - City or Town	n, State			
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Bal	Deparential Important in any ir		21. Signature of Funeral Service Licensee F. J. J. J. J. J. J. J. J. J. J. J. J. J.	22. Name and Address of Facility HINES-RINALDI FUNERA 1800 New Hampshire	Ave, Sil	ver Spring.	MD 20904			
Ш			shock, or heart failure. List only one cause on each line.		i lespilatory affest,	lr 1r	nterval Between Onset and Death			
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	Examiner		Sequentially list conditions, b.	Embelium		4	Tmonth			
	D tig	iner	if any, leading to immediate Due to (or as a consequence of):							
_	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
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Вох	ondir use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of delivery				
O. B		by Physician/Med		5 Other (specify)		Month Da	ay Year			
<u>.</u>	that the ed by th detache	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	cause of death?				
ds	w requires that s been signed t should be det	d by			1 ☐ Yes	2 □ No 3 Probab	ly 4 Unknown			
CO	law rec as beer 2 shou	Completed			24a. Was an	24b. Were autops	y findings available			
R	9 L B	om			autopsy performed 1 Yes 2	? death?	letion of cause of			
/ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death						
of Vital Record		2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		ne 5 Residence	6 Other (Specify)				
	ding I h. After funer	tion	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury		tou. Describe now ii	ijury occurred				
Division	il or Attending after death. I Diractor: Afte d in by the fune	Certification;	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm.	street, factory, office 2	28f. Location (Street	and Number or Rural R	loute Number,			
ā	tal or s afte ai Dirr	Cert	4 ☐ Homicide building, etc. (Specify) City or Town, State)							
	To tha Hospital or Attending Phys within 24 hours after death. To the Funeral Diractor: After this completely filled in by the funeral di	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as state and place, and due to th	ed. e cause(s)			
	To tha I within 2 To the I complet	Ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Da	y, Year)			
	2		30. Name and address of person who completed cause of death (Item 23a) (Typ	40060335	Oct	ober 25	2004			
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	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	+327 O(ney.	MD 2	20832				
	Registi		OCT 27 2004	AGOURAN						